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"The highly transfused & vCJD infection risk: draft note to Brian McClelland"

Document Type:	**Formal**
File Title:	**GHP - CJD - Joint ACDP/CJDIP Working Group on Highly Transfused**
File Reference:	**GHP/008/027**
Protective Marking:	**No Marking**
Filed by:	**Mark Noterman/CQEG/DOH/GB** on **24/04/2007** at **13:42**
Created by:	**Mark Noterman** on **15/02/2007** at **14:31**

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Modification History Prior To Moving To Archive:

Modified Date and Time	Details
26/04/2007 14:15	Modified registered file
01/10/2007 11:07	Refiled from GHP/008/030

Mark Noterman
15/02/2007 14:31

To: Lee Robertson/PH6/DOH/GB
cc: Ailsa Wight, Stephen Dobra/SAT/DOH/GB GRO-C Peter Bennett/SAT/DOH/GB GRO-C
bcc:
Subject: The highly transfused & vCJD infection risk: draft note to Brian McClelland

Lee

I spoke to Stephen this morning and they are content with the draft below, which Ailsa has already approved.

Can you please do this as a letter for Ailsa's sig. and then send it off to Brian with copy of the earlier correspondence attached at the end of this chain.

Many thanks

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Mark Noterman
14/02/2007 11:33

Dobra/SAT/DOH/GB GRO-C

To: Ailsa Wight, Stephen
cc:
bcc:
Subject: The highly transfused & vCJD infection risk: draft note to Brian McClelland

Ailsa/Stephen

Draft note to Brian McClelland attached below, grateful for your comments.

Many thanks

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To: **Brian.McClelland** GRO-C

Dr Brian McClelland
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Brian

As you know we are keen to access, to inform the joint ACDP TSE Working Group/CJD Incidents Panel work on highly transfused patients, information derived from the data that you hold in the Scottish Transfusion Epidemiology Database (STED).

Our suggested measure of risk in each case is the number of donor exposures arising from all blood components including Red Blood Cells, Platelets, Fresh Frozen Plasma and cryoprecipitate. We suggest that one dose of platelets should count as four donor exposures, unless it is certain that it was a dose produced by apheresis. Similarly, for cryoprecipitate, the number of donors in the pool needs to be calculated.

We are using the definition of highly transfused as a transfusion recipient having 80 or more donor exposures since 1980.

Whilst we understand STED only provides information on transfusions since 2002, your data could help in identifying which types of patients in terms of diagnostic groups and surgical procedures are most likely to be highly transfused. It will enable improved estimates to be made of the numbers of recipients that are high transfused, their survival and the proportion that have high or medium risk surgery.

The first four questions below may be answered by considering donor exposures for recipients still alive on 31st December 2006 (whether highly transfused or not) for both (a) the exposures over the period 2002-2006 and (b) the exposure in 2006 only:

1. What is the distribution of the number of donor exposures for all transfusion recipients alive on 31st December 2006?

2. What proportion of all recipients had 80 or more donor exposures?

3. What is the distribution of the number of donor exposures for recipients by diagnostic group?

4. What proportion of recipients in each diagnostic group has 80 or more donor exposures?

The following questions are more difficult

5. For the total highly transfused recipient population and for the highly transfused in each diagnostic group what proportion of recipients survived for 1,2,3 & 4 years and what proportions had high risk surgery, medium risk surgery, other surgery or no surgery (in the period after becoming heavily transfused) in the next 1, 2, 3 & 4 years? This will not be straightforward to answer and a suggested approach is given in the footnote I suggest there is a need to look at those having 80 or more donor exposures at 31st December 2002 and look at the probability of them having high, medium or low risk surgery or surviving over the next 1, 2, 3 & 4 years: then those having 80 or more donor exposures at 31st December 2003 and look at the probability of them having high, medium or low risk surgery or surviving over the next 1, 2 & 3 years; then those having 80 or more donor exposures at 31st December 2004 and look at the probability of them having high, medium or low risk surgery or surviving over the next 1& 2 years, etc.

6. What proportion of recipients are in each of the following states within 1, 2, 3 & 4 years after first being recorded in the database

   - alive and with less than 80 donor exposures
   - alive and with more than 80 donor exposures
   - dead with less than 80 donor exposures at death
   - dead with more than 80 donor exposures at death

These are the six main questions, supplementary information would include data on the age and gender distribution of the highly transfused by diagnostic group and the number of transfusion episodes by diagnostic group for the highly transfused. Annex A includes a suggested

classification of the diagnostic groups, based on that used by Angus Wells.

I would be grateful if you, or STED colleagues, could discuss the precise requirements for interrogations of the database with my colleague Stephen Dobra who with others in our analytical team are leading this piece of work.

I understand that provision of these interrogations may require additional expenditure and we are willing to share funding of these costs if required.

Many thanks

Ailsa Wight.

ANNEX A

Diagnostic group	Subgroup
Haematology	TTP
	Aplastic anaemia
	Inherited red cell disorders
	Other haematology
	Acute myeloid leukaemia
	Myelodysplastic syndrome
	Myeloproliferative disorders
	Coagulation/platelet disorders
	Acute lymphoblastic leukaemia
	Myeloma
	Lymphoma
Hepatobiliary & pancreas	Other
	Liver transplant
	Surgery for cancer
	Liver disease
Digestive system	GI surgery
	GI bleed
Renal tract	Renal failure
	Other
Cardiac surgery	
Vascular system	
Respiratory	


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