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MSBT 1/5

CONFIDENTIAL TO COMMITTEE MEMBERS

NOT FOR PUBLICATION

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

MINUTES OF THE FIRST MEETING HELD ON 4 OCTOBER 1993 IN ROOM 102A SKIPTON HOUSE

Chairman:	Dr J S Metters
Members:	Dr D W Gorst Dr H H Gunson Dr R Lane Miss R H H Lord Dr R Mitchell Dr P Mortimer Dr R J Perry Dr R E W Warren Professor A Zuckerman
Observers:	Dr J Hilton Dr A Keel Mr J S Sloggem
Secretariat:	Dr A Rejman Mr J Canavan Mr D Burrage Ms M Sandillon

1. Chairman's Introduction

The Chairman welcomed former Members of the Advisory Committee on the Virological Safety of Blood and new Members who had not served on that Committee. The Chairman also welcomed the Observers and Secretariat.

2. Apologies for absence

The Chairman reported that he had received apologies for absence from Dr McMaster, Professor Williams, Dr George, Dr Mock, Dr Halliday and Dr Purves.

3. Terms of Reference

Members had no questions about the terms of reference of MSBT. The Chairman confirmed that Yersinia was now within the Committee's remit.

4. **Minutes of the last ACVSB meeting held on 9 February 1993**

The minutes were agreed by the former ACVSB Members present.

5. **Matters arising**

5.1 Combined HIV/HTLV test (minute 4.7).

Dr Rejman reported that an amended Biokit test had received favourable evaluation by PHLS, and that a pilot study would be run by Leeds RTC with confirmatory tests by the PHLS laboratory at Leeds supported by PHLS Colindale. A report would be submitted to MSBT via RTDs committee.

5.2 Generic protocol for the admission of donors to the active panel (minute 6).

Dr Rejman reported that ACTTD and RTDs were content with the revised protocol, which was tabled for Members information.

5.3 Hepatitis A in patients with Haemophilia A (minute 7).

Dr Rejman reported **in confidence** from the discussion of the ad hoc working party on biotechnology/pharmacy advising the CPMP. Hepatitis A outbreaks in Italy, Eire, Germany and Belgium had been linked to plasma fractionated by Octopharma and an identical process under licence in Italy. Octopharma had accepted that transmission of Hepatitis A through their process was theoretically possible and were proposing the addition of heat treatment to the process. In the meantime CPMP continued to suspend the marketing authorization of the Octopharma product. The viral safety group of the working party would be considering validation procedures in respect of virucidal steps for enveloped and non-enveloped viruses for all blood products. Dr Lane asked that consultation should occur with fractionators before proposals were confirmed. He was advised to discuss further with MCA.

5.4 Guidelines for the reporting of Yersinia by blood (minute 8)

Dr Mitchell reported that RTDs were considering recommendations to improve the reporting system of transmission of possible bacterial infection and would report to MSBT. Dr Warren said it was important that microbiologists were included in the notification system.

5.5 Parvovirus B19 contamination

The Chairman said that the Committee would return to the

subject of Parvovirus B19 contamination (minute 4.8) at a forthcoming meeting.

6. Routine screening of blood for anti-HBc (MSBT 1/2 and MSBT 1/3)

6.1 The Chairman said that this item had previously been considered by ACVSB (paper MSBT 1/2 contained a compilation of extracts from ACVSB minutes and papers), particularly in the context of whether to test people with a history of jaundice. The Chairman asked Dr Rejman to speak to paper MSBT 1/3 and invited the views of the Committee on the options in Annex 7 of the paper.

6.2 Dr Rejman said the decision needed was whether it was worthwhile to supplement HBsAg testing, which did not detect all hepatitis B transmission, with testing for anti-HBc. The Committee's advice was sought on the feasibility of introducing such a measure and the resource implications. It had been argued that anti-HBc positive blood donors could be beneficial to the plasma pool by preventing transmission from donations in the pool if they also had a significant amount of anti-HBs. There were also separate issues for organ/tissue transplantation. The need for urgent transplantation would not always allow time for a full range of tests which could lead to a very significant loss of organs.

6.3 Professor Zuckerman said that the problem of confirmation of anti-HBc was still significant, and that Anti HBc IgM might have to be considered. Other markers of hepatitis B were unlikely to be helpful and the specificity of many of the tests was in doubt. Professor Zuckerman reminded the Committee that introduction of hepatitis C screening had been delayed because of unavailability of confirmatory tests, and said that he was not comfortable with current commercial anti-HBc tests. The use of anti-HBc positivity as a lifestyle marker was not very sound scientifically, and history would eliminate many risk categories except occupational and ethnic.

6.4 Dr Mitchell said that there were undoubtedly cases where anti-HBc was the only marker and that RTCs would never have transfused knowingly. Although work was in progress on a standard for deciding whether to accept or reject a donation, none was yet available, and a confirmatory test was also needed. Dr Gunson said that the new Abbott test would be a strong market leader if positives were truly positive, but the test had yet to be licensed.

6.5 Dr Gunson informed the Committee that 4 actions had been brought under the product liability section of the Consumer Protection Act by recipients who had contracted Hepatitis B and where donors were anti-HBc positive, and said that there was a growing perception among RTC Directors that anti-HBc screening should be introduced because of the possibility of prevention of hepatitis infection. Dr Gorst thought that while the general view was that blood should be safe, but not

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at any cost and recipients were primarily concerned with HIV.

6.6 Professor Zuckerman questioned the extent to which hepatitis B had been transmitted through anti-HBc positive donors who were HBsAg negative. It was suggested that Julia Heptonstall (CDSC) might be able to provide some of this information. Dr Gunson said that there were difficulties in obtaining evidence of the numbers of recipients of anti-HBc positive blood who had developed hepatitis but the number of infections was thought to be in the range 10 to 100. Dr Mortimer thought the number would be in the lower end of the range and stressed the low prevalence of hepatitis B in the UK compared with some other countries. Members agreed that a proportion of those, probably half, would have no clinical symptoms at all, as in many cases hepatitis B was asymptomatic, and the majority of the remainder would have no permanent effects. Moreover, ~~recipients of~~ half of the blood transfused would die within the year of their underlying clinical condition. ~~of~~ recipients who

6.7 The Committee questioned whether the very substantial cost of removing the risk to very small numbers, estimated at around £3m, or between £15,000 and £20,000 per District, would be worthwhile, and thought that the BTS could use the money more effectively.

6.8 Dr Lane said that what was considered unsafe for whole blood should also be considered unsafe for plasma pools. Although he would not want to depend on antibody for protection against hepatitis B in plasma pools, he believed anti-HBs to be protective. Dr Perry echoed Dr Lane's concerns, but said that in this case the cost benefit ratio was not a good one. Dr Warren asked if information about the infectivity of anti-HBc positive blood transfusion could be obtained by looking at plasma pools. Dr Lane thought that it would be problematic to find a representative way of doing this.

6.9 The Committee noted that, apart from France, no European country used this test routinely. In the US anti-HBc was introduced as a surrogate test for non-A non-B hepatitis before Hepatitis C tests became available. Members pointed out that it would in any case be very difficult to regulate against non UK plasmapheresis centres fractionating anti-HBc untested plasma.

6.10 Miss Lord said that she had no knowledge of hepatitis B transmission in transplant cases although the risk of clinical disease was greater because of immunosuppression. Additionally, the large number of potential recipients of, for instance, skin, from one donor could make this important. For the present a better test was needed.

6.11 The Chairman said the options for the Committee were threefold, to recommend either that anti-HBc screening be introduced, or that it be rejected, or that a decision should be deferred until sufficient data became available.

6.12 The unanimous view of the Committee was that Ministers should be advised that introduction of routine screening for anti-HBc in blood donations and organs or tissues for transplantation was inappropriate. If further data became available, the Committee would review the position. The Chairman said that draft minutes would be circulated to Members for comment.

6.13 Dr Mitchell understood that 100% screening for anti-HBc had already been introduced in Liverpool. It was agreed that the Secretariat should investigate and that, if confirmed, the RTC should be advised to stop routine screening for anti-HBc.

7. Promoting the safety of human organs for transplantation (MSBT 1/4)

7.1 The Chairman invited Members to give their initial reactions on the joint UKTSSA and NIBSC working party document (MSBT 1/4) at the meeting, and to address more detailed comments in writing to the Secretariat, who would use them to prepare a paper for fuller discussion at the next meeting. The intention was that the guidelines would be issued to clinicians and others in the transplant field.

7.2 Miss Lord said that the guidelines were needed, and she welcomed them, subject to further scrutiny of some parts, particularly those covering matters which were to be left to the judgement of clinicians.

7.3 Reservations were expressed about the microbiological section, which would need to be redrafted. Some of the advice presupposed definitive diagnosis on the donor whereas the clinician may not know as much about the threat as microbiologists. The document tried to put the testing of organ donors on the same basis as blood donors, but the practicalities needed to be considered before the document was widely disseminated.

7.4 The Committee agreed that after discussion of their detailed comments at the next meeting, the Committee would consult UKTSSA and NIBSC. The Chairman said that the document should offer a flexible framework of guidance for transplanters in which to operate.

7.5 The Committee agreed that the British Transplant Society and the appropriate Royal Colleges should be consulted, including Scottish Royal Colleges.

7.6 The Chairman asked for Members to submit their written comments. The Chairman was content for Members to consult in confidence with trusted colleagues on the guidelines pre publication. It was agreed that the Secretariat would write to John Evans at UKTSSA with the preliminary view of the Committee and that the Chairman would consult CMO on whether the guidelines should be issued as CMO guidance.

8. EC Directive on blood products - progress report

Mr Sloggem said that there were no developments on the Directive to report.

9. Chairman's report on potential blood and organ donors who have received human pituitary-derived hormones (including gonadotrophins).

9.1 The Chairman said that the parallel with human growth hormone was so strong that he had written to Dr Evans at UKTSSA and to Dr Gunson, without waiting for a formal discussion at the MSBT.

9.2 The Chairman asked for the Committee's views on whether recipients of Dura Mater should be deferred from donation. Dr Mitchell said that there had been reports of 5 cases in MMWR last year of Dura Mater transmitting CJD.

9.3 The Committee acknowledged the difficulty in determining who were recipients and who were not, given the wide uses of Dura Mater beyond the CNS. The number of recipients was not small, around 20,000. Whereas the majority of recipients of human growth hormone could be identified, and 50% of recipients of pituitary gonadotrophin were known, the identities of many dura mater recipients were not. There was therefore a potential for losing an unnecessarily large number of donors, due to the uncertainty of whether they had received dura.

9.4 The Committee thought that in principle, it was logical to defer Dura Mater recipients, subject to resolution of the practical difficulties. It was agreed that further data should be obtained, and discussed with MCA before the Committee's next meeting.

Any other business

10. It was agreed

i. the Secretariat should prepare a paper on tissue banks, and

ii. the Committee should explore retrospective identification of contamination of pools at a future meeting. A draft had been prepared by Dr Perry of PFC and this would be discussed with BPL in the first instance.

Date of Next Meeting

12. The Secretariat would check Members' availability for the next meeting of the Committee, in February 1994.