Note of an ad hoc meeting to discuss vCJD and blood
Skipton House, 15 December 2003

Present:

Lindsey Davies MSBT (Chair)	[ ] WAG
James Ironside UK CJD SU	Glenda Mock DHSSPS NI
Don Jeffries CJD Incidents Panel	Andre Hare DH EOR
Peter Smith SEAC	Peter Bennett DH EOR
Catherine Boyle SEAC	John Stephenson DH
Patricia Hewitt NBS	David Harper DH
Martin Goram NBS	Ailsa Wight DH
Liz Reynolds NBS	Richard Gutowski DH
Chris Hartley NBS	Pip Edwards DH
Tony Napier [ ]	John McCracken DH
Brian McClelland [ ]	Siobhan Jones DH
Aileen [ ]	Jill Taylor DH

Lindsey Davies welcomed attendees to the meeting, and expressed gratitude that people had changed their diaries at short notice in order to be present. She drew the group's attention to a note of items on which CMO wanted advice.

vCJD Incident

James Ironside outlined the medical history of the patient who died earlier in the autumn. Pat Hewitt filled in details available to the BTS.

During an operation in 1996 the patient received 3 units of blood, one of which came, so far as could be deduced from incomplete records, from a donor who developed symptoms of vCJD in 1999. Red blood cells from the same donor's only other donation were transfused later in 1996 into another patient who died five months later of cancer. Plasma and platelets had also been obtained from these donations, not all of which had been traced to named recipients.

Research

John Stephenson and James Ironside reported the results of research on animals (sheep and squirrel monkeys). These suggested that BSE/~~vCJD~~ could be transmitted at least 20% via blood transfusions although transmission rates appeared to be ~~relatively low, less than 100%~~ in sheep. In squirrel monkeys, it was still unclear whether transmission had occurred.

Transmission route

In the light of the case history and the research evidence the group concluded that while it would be impossible to be certain how the patient got vCJD, the probable route was via the blood transfusion.

Policy implications for protection of the blood supply

It was suggested that there was little clinical justification for using plasma in many cases, and that clinicians should be discouraged from using it. Where it had to be used, children born after 1.1.96 were due to receive fresh frozen plasma imported

from the US. There was an argument for extending the use to FFP to patients who needed it on a regular basis. The cost of providing FFP for children born after 1.1.96 would gradually rise as this group became a larger proportion of the population, although at some point they could themselves become blood donors.

The BTS had been extending the collection of platelets by apheresis, though had not made as much progress as it had hoped. ~~[I didn't follow the discussion about childhood leukaemia etc.]~~ The meeting suggested that MSBT should look at the implications of extending the apheresis programme, particular to targetting children with leukemia as recipients exclusively of aplatelets obtained by apheresis

Autologous transfusions were not an option for platelets. In respect of red blood cell recipients the BTS estimated that only 5% of patients undergoing elective surgery met the criteria for being donors. Thus although pre-operative depositing of blood could make an impact on the demand for blood, its effect would be relatively small. Intraoperative cell salvage was useful, not just because it recycled blood cells, but also because it raised the awareness of surgical teams in techniques for reducing blood loss in the first place. There was a need for clinical governance mechanisms to ensure wider awareness and application of techniques that reduced the need for blood transfusions. [What was the comment about the National Blood Committee?]

autologous

One option already looked at would be to exclude recipients of blood transfusions from donating blood. In the light of the suspected case of blood transmission, it was agreed that this should be looked at again. There was however a need to avoid measures which unmanageably reduced the blood supply. Similar issues were raised in respect of tissue transplants and stem cells. There would also be a need to put counselling procedures in place for people whose donations would be refused. The NBS was embarking on a major training programme in the New Year. If a decision to introduce this measure could be coordinated with the roll-out of the training programme that would simplify the process of implementation.

It was estimated that 30ml of plasma remained in each unit of packed red blood cells. There was a need to look at the effects of removing more of this remaining plasma, particularly for people such as thalassaemia patients who needed regular transfusions.

The ethical aspects of differentiating between different groups of blood recipients would need to be considered.

Action needed to follow through on other individuals who received blood from someone who later went on to develop vCJD

The meeting noted that the Incidents Panel were keen for the Health Protection Agency to contact and inform recipients of blood from donors who subsequently developed vCJD. The also noted the desirability of monitoring the health of this group.

Further risk assessments relating to plasma donations

[Pip?] An assessment of the risk of exposure to vCJD in blood components and plasma derivatives had been commissioned from Det Norske Veritas by the DH. The risk assessment had been considered by SEAC, MSBT and the CSM. The basis for the risk assessment for blood components was endorsed by all 3 committees. Three approaches to the assessment of the risks from plasma derivatives were

put forward by DNV. One of these approaches was considered not scientifically sound by the expert committees but there were insufficient grounds for opting for either of the remaining two. The CJD Incidents Panel convened an expert group comprising Panel members and stakeholders ~~(patient groups)~~ to advise on which approach to use. The Panel accepted the view of this group that the more precautionary approach should be adopted. The DH was working with fractionators to collect the information and carry out individual risk calculations based on the Panel's decision. This process was nearing completion.

How best to notify the individuals concerned

[ ]

Research

Research that helped the early development and introduction of a test to allow screening of blood was desirable.

[Ailsa made some point about transmission studies]

The DH Research Division was in the process of planning the next series of transfused sheep experiments, ~~and intended to compare~~ the infectiveness of ~~platelets and plasma~~. Any suggestions for further work on sheep should be sent promptly to John Stephenson.

which included studies on

different blood fractions

Conclusion

Lindsey Davies thanked the group for their helpful discussions.