Report prepared by:	Dr. T. Snape	Summary report on the recall of factor VIII batch HL3186 occasioned by probable diagnosis of AIDS in a contributing donor.
Report reference :	INCREP02	
Distribution (BPL):	Dr. Lane	
	Mr. Mallory	
	Mr. Vallet	

1. Donor condition and products affected

1.1 A donor was admitted to Bournemouth Hospital with a skin rash consistent with Kaposi's sarcoma, leukopenia and anaemia. Biopsy results awaited. Donor admits to homosexual activity but was VDRL negative when he donated blood on 25.9.84 (this donation was separated at Wessex RTC but plasma was not despatched to BPL).

The original report of this incident, telephoned by Dr. D. Smith on 2.10.84, was confirmed in writing by Dr. M. Barnes (letter of 4.10.84 attached).

Dr.Barnes confirmed the following circumstances concerning the donor (telephone 12.10.84) :

i. biopsy confirmed early Kaposi's sarcoma;
ii. plasma samples tested by Dr.Tedder were positive for HTLV-III:
iii. the donor has now been diagnosed as suffering from pneumocystis pneumonia.

1.2 Plasma donation number GRO-A was collected into an IPP on 27.3.84 and despatched to BPL on 6.4.84 in box No.SP4333. This pack was used in the manufacture of batch HL3186.

No factor IX was recovered from the cryosupernatant.

No fraction II was recovered from the A + I precipitate.

Fraction V was recovered and is presently held as L938 and L939.

Factor VIII batch HL3186 was distributed as follows :

Wessex RTC 485 vials (sent 10th August)
Cardiff RTC 400 vials (sent 15th August)

1.3 Time-expired plasma from the donation of 21.11.82 was received at BPL as pool no. CJ162TE (ie from Leeds RTC). This was subsequently fractionated yielding fraction V concentrate L825. Two batches of PPF were manufactured from this concentrate:

AD1305 - labelled but not released for issue; held at Bullens,
AD1315 - finished but QC incomplete; held on site.

No fraction II was recovered from the A + I precipitate.

Mr [illegible]

You will wish to note this report. In particular comments by Dr Snape on p.4 para 5.2 & 5.3.

GRO-C

26/10.

1.4 The donor also gave blood in the West Midlands Region on 14.2.83. This donation was used as whole blood; no components were sent to BPL.

1.5 There is no indication from records maintained at Wessex RTC that any other plasma from this donor has been received at BPL during the last five years (but see the penultimate paragraph of Dr. Barnes' letter).

2. Actions to secure/recall implicated products

2.1 Dr.Smith (Wessex) was informed of implication of HL3186 (telephone 2.10.84, TS) and was asked to recall all vials including any held by patients for home therapy.

Dr.Napier (Cardiff) was unavailable but Mr.Booth (Sen.Ch.MLSO, Cardiff) was informed (telephone 3.10.84, TS) and was asked to recall all vials of HL3186, including home therapy issues.

Both telephone conversations were confirmed in writing (3.10.84, copies attached).

2.2 Fraction V concentrate L938 and L939 were secured and labelled 'HELD' - although PPF might be argued safe in respect of viral transmission it is not considered that the risks possibly associated with further processing can be justified. These fractions will be held against the possibility of development of suitable test methods.

2.3 PPF batch AD1305 will be held pending results of investigations to determine process efficacy of heat in relation to HTLV.III inactivation. Provided it can be demonstrated that wet-heat pasteurization inactivates the virus, the product may be considered for release.

PPF batch AD1315 will also be held; the situation here is more complex in that completion of finished product QC would require that further analytical work be carried out on unheated samples.

2.4 All samples of intermediate and finished products held in house have been secured, and will be held pending development of appropriate test methods.

3. Results of factor VIII recall

3.1 The 400 vials of batch HL3186 despatched to Cardiff break down thus:

Stock held at RTC - 150 vials
Heath Park, Cardiff - recovered 101 out of 150 vials (6 patients),
Morriston - recovered 51 out of 60 vials (2 patients),
Carmarthen - recovered 36 out of 40 vials (1 patient).

A total of 338 vials was recovered; 9 patients received the batch.

3.2 The 485 vials of batch HL3186 despatched to Wessex break down thus:

Alton (LMT College) - recovered 105 out of 200 vials,
Dorchester County - recovered 5 out of 25 vials,
Salisbury - all 70 vials used,
Winchester - all 10 vials used,
Bournemouth - recovered 60 out of 60 vials,
Southampton - recovered 1 out of 60 vials,
Portsmouth - recovered 6 out of 50 vials,
Newport, IOW - recovered 10 out of 10 vials.

A total of 187 vials was recovered; the number of patients involved was not reported.

4. Follow-up actions

4.1 Dr.Smith (Wessex) was asked to report any plasma from this donor despatched to BPL (or PFL) within the last 5 years. Dr.Smith was also asked to determine whether the donor had a history of attendance at local special clinics for venereal disease. (Dr.Barnes subsequently confirmed that this was the case.)

4.2 Dr.Tedder (Middlesex) was consulted but indicated that he did not wish at the moment to receive samples of plasma fractions since he did not feel test methods presently in use were appropriate. He did however ask to receive a sample from the most recent donation (September, 1984) and this was arranged with Dr.Smith (Wessex).

4.3 Dr.Craske (PHLS Manchester and Chairman of the Haemophilia Centre Directors' working party on viral transmission of disease) was consulted and asked to be supplied with a list of haemophilia centres supplied with HL3186, in order to initiate follow-up studies on patients treated with the batch. Dr.Craske will be asked to provide BPL with a list of haemophiliacs identified as having received batch HL3186.

4.4 Medicines Division appraised of the situation (Dr. K. Fowler and also 'Defects Report' section).

5. Observations on the incident

5.1 With an incubation period exceeding two years it is likely that a donor diagnosed as suffering from AIDS will compromise more than one pool of plasma fractionated at BPL.

5.2 In this particular instance, the last (and most damaging) donation was received at BPL on 6th April 1984, pooled for fractionation on 17th May 1984 and issued for clinical use on 10th August 1984. This timetable is consistent with the five week period of quarantine presently supportable for fresh frozen plasma and the irreducible six to eight week delay from pooling plasma to release of factor VIII concentrate for clinical use.

Enforcement of a three month quarantine period would not in this instance have avoided the loss of resource resulting from the plasma pool being compromised by a single donation; it would almost certainly have avoided patient exposure to the product however.

Enforcement of a six month quarantine period would have prevented release of the batch for clinical use; it would also have allowed the donation to be excluded before pooling, thus avoiding a very expensive reject situation.

This incident must be an extremely cogent argument for the establishment of cold-storage facilities capable of supporting a six-month quarantine of fresh frozen plasma.

5.3 The appearance of this donor at three different Centres within two years clearly underlines a fundamental problem when carrying out follow-up of donor incidents of this sort. Surely central co-ordination of donor records is unavoidable.

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T.J.SNAPE
Head of Quality Control