SACTTI 34/98

PF/CAP

06 May 1998

To National Medical Directors

Dear

Re: HCV Infections probably acquired by Transfusion

My purpose in writing is to outline recommendations agreed at the meeting of SACTTI in March of this year in relation to the requirement to follow up reports of possible transfusion acquisition of hepatitis C infection identified within the PHLS or diagnostic laboratory network. This issue was brought to the attention of SACTTI sometime ago. The Central Public Health Laboratory Service identified a number of cases of hepatitis C reported to them through their surveillance network where transfusion was identified as the likely source of infection. In many instances the patients had not been identified through routine investigation of cases by local Blood Centres nor through the National HCV Lookback Programme. Dr Pat Hewitt in conjunction with staff at CPHL was asked to identify practical mechanisms whereby such cases might be investigated.

I enclose a paper (SACTTI 30/98) that was tabled at the SACTTI meeting in March. SACTTI recognise that the identified procedures might not be applicable to all UK Transfusion Services, particularly so in Scotland where a separate surveillance system is in operation. I was however tasked to write to all four National Medical Directors to ensure that you are aware of this issue and that the possibility of initiating similar approaches might be considered.

The paper assumes that all suspected transmission related to transfusion of anti-HCV tested blood ie transfused after September 1991 are already being fully investigated. The proposed scheme will apply to transfusions taking place between 1988 and initiation of routine testing in September 1991. 1988 was selected on the basis of medico legal consideration arising through the current HCV litigation process.

Co-ordination of the project will be undertaken through CDSC. Initially the project will be run for twelve months commencing with reports received by CDSC on 1 January 1998. At the end of this period CDSC will compile a report for consideration by SACTTI in early 1999. At this stage a decision on the appropriateness of continuing the programme on a long term basis will be made.

This project aims to provide a pragmatic solution to a difficult problem. Hopefully the mechanisms identified will enable clarification on the likelihood of transfusion as a source of infection in reported cases. If you have any questions or concerns in relation to this proposal then I would suggest that these could be considered at the meeting of

the UKBTS/NIBSC Executive planned for June this year. If you feel this will be valuable I will be grateful if you will let me know in advance and identify the specific issues that you would like to be discussed.

Best wishes.

Yours sincerely

GRO-C

DR PETER FLANAGAN
Chairman, SACTTI