

11<sup>th</sup> March 2009

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**Confidential**

Dr Aleksandar Mijovic  
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Please reply to:-  
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Dear Dr Mijovic,

**Re: Patient** [GRO-A]  
**Hospital No:** [GRO-A] (other details unknown)  
**Our Ref: PTY/05/09**

On 3<sup>rd</sup> February 2009, Mark Zukerman notified you about a patient with acute hepatitis B, diagnosed in December 2008. You passed the information to me, with a comment that we would require a copy of the virology test results. Mark responded to indicate that the tests were carried out in Lewisham and that he would obtain a copy of the test results.

We forwarded to you a notification form on 9<sup>th</sup> February 2009, requesting details about the infected patient, the test results, and a copy of the transfusion laboratory record for the patient in question. To date, I have not received any of this information.

According to Mark's email, patient [GRO-A] underwent cardiac surgery in May 2008 and an orthopaedic procedure in July 2008. The patient received 2 units of "blood products" on each occasion. The donation numbers were quoted in Mark's email.

Whilst awaiting the further information, we identified the 4 donations listed in Mark's email and established that all 4 donors had re-attended at least once since the donation transfused to patient [GRO-A] in the summer of 2008. The archived samples from all 4 subsequent donations were retrieved and tested for the presence of anti-HBc. All 4 samples were anti-HBc negative. These results exclude any of the donors as having been infected with hepatitis B. The 4 blood donations listed in Mark's email cannot therefore be implicated as a source of hepatitis B infection in patient [GRO-A].

I would stress that we have not received the minimum information necessary in order to document the details of this case. In particular, donation numbers have been provided in an email and not from a computer laboratory print-out. We therefore cannot vouch for the accuracy of the donation numbers provided to us.

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If you could now provide the information requested, we can include it in the file and confirm that the correct donations have been investigated. Otherwise, I am now closing our investigation with the conclusion that patient GRO-A hepatitis B infection was not due to the transfusion of the 4 units of "blood products" notified to us in Mark's email. We have assumed that the blood products in question were red cells.

This case will be reported to SHOT, according to our usual procedure. No doubt an investigation into other possible sources of infection will now be carried out at King's College Hospital.

With kind regards.

Yours sincerely,

GRO-C

Dr P E Hewitt  
Consultant Specialist in Transfusion Microbiology  
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cc Dr Mark Zuckerman, Consultant Virologist, King's College Hospital