NATIONAL BLOOD AUTHORITY

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Dear Diana

Firstly may I thank you for the helpful letter you sent me with regard to the supply and demand situation for various specific immunoglobulins. In the light of your comments I am hopeful that future liaison between BPL and PHLS will from henceforward go forth on a better footing so thank you again for your frank and helpful comments.

On a completely separate issue and in the wake of the "HCV Look Back" programme it occurred to my working group on "Serious Hazards of Transfusion" that we should be able to make better use of information reported to PHLS. This working group is trying to devise a reporting system for serious adverse transfusion incidents so that an anonymised UK wide central registry of transfusion hazards can be developed. Immediate events, such as haemolytic transfusion shock will be fairly easy to define and catch. The incidence of post transfusion viral infections will be much more difficult to establish, although Kate Soldan will hopefully be able to at least establish how many have been reported to the transfusion centres in recent years.

With the current heightened awareness of everybody to the association of hepatitis C and blood transfusion I wonder if you could assist us in improving the current reporting system for post transfusion hepatitis by ensuring that the transfusion history is recorded when requests are made for hepatitis testing and that feedback is then automatically provided to the local transfusion centre should the hepatitis test prove to be positive in the presence of a past history of transfusion.

I am not sure how complex or successful such a system might prove to be or how burdensome to both the PHLS and the NBS, but at present we have little information on what the true incidence of post-transfusion hepatitis is in the UK. Although Kate Soldan's work will get us nearer to the truth, our current reporting system is somewhat haphazard and it

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might be a good move to think about developing a better system now whilst there is a general atmosphere of increased awareness amongst PHLS, NBS and clinical staff about transfusion transmitted hepatitis i.e. is there a mechanism whereby a one off random testing exercise could be developed into an automatic feedback habit for the future?

I'd be grateful if you would have a think about this. I am also aware that Philip Mortimer (who joined our Working Group last time) will be discussing this issue with Julia Heptonstall.

Best wishes.

Yours sincerely

GRO-C

Dr E Angela Robinson
Medical Director

cc Dr Lorna Williamson, Blood Transfusion Hazards Working Group