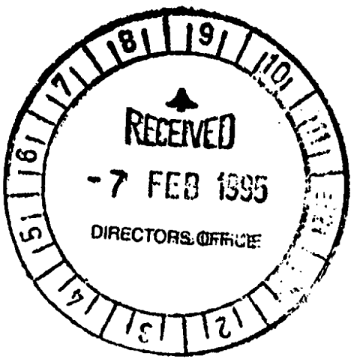
CCHG RR UMCU.

Dr Forman

GRO-C

NBA

# NATIONAL BLOOD AUTHORITY

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6th February 1995

Dr J F Harrison
Medical Director
North East Thames Regional Transfusion Centre
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Dear Jean

**HCV Look Back**

I am enclosing the revised guidelines for Action by RTC.

At this stage, please do not proceed to the hospital notification stage. The draft letters to be used for the notification stages and the proforma to record all stages of the process are currently under consideration (including medico-legal advice). The format should be finalised at the next meeting of the MSBT Working Party to be held on February 24th 1995.

I will notify you and send copies of the draft letters and proposed record keeping proforma as soon as possible after this meeting together with revised guidelines on how to proceed with the hospital notification stage.

Many thanks for all your hard work so far. It is important that we maintain a consistent approach from now on and that we all act in concert. Thank you for your patience so far.

Best wishes.

Yours sincerely

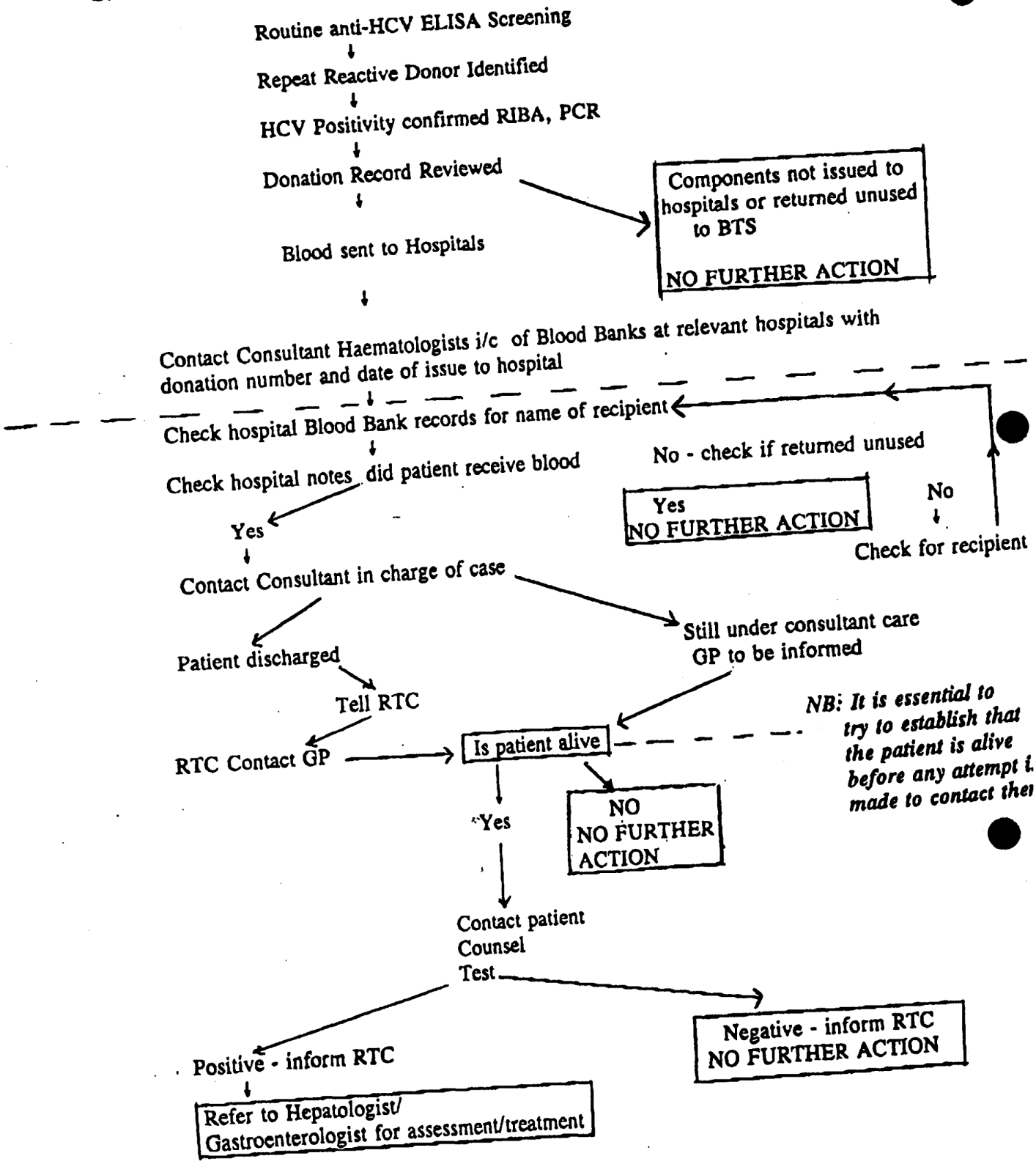
GRO-C

**Dr E Angela Robinson**
**Medical Director**

Encs.

23/1/95

# DRAFT ALGORITHM FOR LOOKBACK FOR HCV



ANNEX 1 (Revision 2)

# LOOK BACK FOR HCV - DRAFT (1/2/95)

## KNOWN HEP C POSITIVE DONORS

1. Action by RTC

All reference laboratory confirmed HCV antibody positive donors to be identified and their donor record examined. There is no requirement to follow up donors whose final HCV test result is deemed to be indeterminate.

All donations given prior to the index HCV antibody positive donations to be identified by donation number together with all the unfractionated blood components prepared from these previous donations.

The fate of all these previously donated units and their associated unfractionated components must be established, ie,

red cells
platelets
clinical fresh frozen plasma
cryoprecipitate

A list of all components issued to each hospital must be prepared. This list must provide the donation number, the type of component and the date of issue to the hospital.

(Plasma that went for fractionation does not need to be traced back but its destination needs to be noted for completeness. Many fractionated blood products are virally inactivated or have never transmitted viral infection. However, clinicians prescribing IvIg will be aware that such products may carry the risk of transmission of HCV and may wish to test patients who received IvIg).

Regardless of how far back individual hospital records are kept the BTS must endeavour to provide a complete list of components issued and the date of issue for each previous donation from reference laboratory identified anti-HCV positive donors. This is crucial information as even if the hospitals no longer have records going back as far, the BTS will still be able to provide an estimate of how many potentially at risk recipients cannot be traced and when and at which hospital they were transfused.

Based on available data, it is sensible to work on the assumption that all previous donations were potentially infectious. It is not therefore considered necessary to test archived samples for the presence of anti-HCV but where available they should be kept. An exception could be made where individual patient circumstances make it desirable to know whether or not they were put at risk, ie, in individual patients where it would be preferable not to inform them that they had been put at risk unless the presence of an HCV infection would alter their management.

**Write in confidence**, to haematologists responsible for the blood banks at the hospitals concerned where blood or blood components from these donors has been sent stating that the donor has subsequently been shown to be hep C positive.

(i) The blood bank record should be scarched to identify the fate of each individual component. Record name of the putative recipient and the date of issue from the blood bank.

(ii) If the unit appears to have been transfused the patient's hospital records should be obtained and the transfusion confirmed. Record whether the patient is:

(a) alive and still under hospital consultant follow up
(b) alive and discharged from hospital care
(c) dead (note cause of death if known)

(If the hospital records indicate blood was given, but do not give details of the donation number, it should be assumed that the implicated donation was used in this individual. If the hospital records indicate no blood was given, then efforts need to be made to try to identify where the blood went).

(iii) If the patient remains under the care of a consultant, the consultant should be contacted using a standard letter, to ask if it is appropriate for the patient to be counselled with a view to testing. A standard letter for contacting the patient will be provided for the consultant who will be required to complete a questionnaire asking for details.

(The following are draft proposals of what needs to be detailed.

(a) In your opinion is it appropriate to contact the patient? YES/NO

(b) If NO, please indicate the reasons why

(c) If YES, do you wish to follow up the patient yourself? YES/NO

(d) If YES, use the standard letter for contacting the patient

(d) If NO, please complete the enclosed form "x" and return to Hospital Haematologist/named consultant at RTC)

(iv) If the consultant looking after the patient decides that it is inappropriate for the patient to be contacted, the reason should be documented and the GP informed.[1]

(v) If the patient has been discharged or the hospital consultant does not wish to be involved, the RTC should be informed and they will contact the GP.[1]

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1 Medical-legal/ethic advice raises the issue here of informing the GP of the potential HCV risk without first asking the patient's consent. There is also the issue of life insurance policies if the GP holds the information that the patient is HCV positive. This issue needs further debate at our next Working Party meeting on how to handle the involvement of the GP at the stages stated above.

The presumption will be that each identified recipient would be counselled and tested. However in exceptional situations such as severe psychiatric illness or terminal physical illness the consultant or GP may feel it inappropriate to add to the patient's distress. It is also essential that the patient's current GP should check to ensure the patient is alive, if letters addressed to deceased recipients are to be avoided.

The RTC is to prepare a file card/data base for each donation cross referenced with a file card/data base for each hospital. A monthly update system modified according to circumstances would be appropriate.