Director

REGIONAL TRANSFUSION DIRECTORS' MEETING

Minutes of the 142nd meeting held on Wednesday 7 June 1972 at 11.30 am in Room D110, Department of Health and Social Security, Alexander Fleming House, Elephant and Castle, London, SE1 6BY.

PRESENT:

Dr W d'A Maycock	- in the Chair
Dr S Murray Dr L A D Tovey Dr C C Bowley Dr J Darnborough Dr T E Cleghorn Dr B Stone (deputy) Dr K Ll. Rogers Dr M M Fisher (deputy) Dr G H Tovey Dr R J Drummond Dr G W G Bird Dr F Stratton Dr D S Smith	- Regional Transfusion Directors
Dr K L G Goldsmith	- Blood Group Reference Laboratory
Dr I S Macdonald	- Scottish Home and Health Department
Dr H B M Lewis	- Scottish National Blood Transfusion Association
Colonel T E Field	- Northern Ireland Blood Transfusion Service
Dr W B Obank Mr W A Walters Mrs R A Tunnard Mr R H Hanson	- Department of Health & Social Security

Apologies for absence were received from Dr Grant and Dr Jenkins.

The Chairman welcomed Dr Fisher, representing Dr Grant, and Dr Stone, representing Dr Jenkins.

1. CONFIRMATION OF MINUTES

The minutes of the meeting held on 22 March were confirmed, subject to the following amendments:-

PAGE 2, PARA.2a. amend sentence before sub-para.i to read:-

"The following points were discussed"

PAGE 7 — 2nd line should read:-

"make an anti-D working standard ..... "

11th line - insert "Liverpool"

PAGE 9 PARA.9 — 4th line:- alter "three" to "two" and delete "Newcastle"

Dr Murray said plans were in hand for rotating Senior Registrarships in haematology.

PAGE 10 line 1. — Insert period after "..... registrarships"

Amend rest of sentence to read:- "RTC Newcastle has at present a whole time SR."

2. MATTERS ARISING

a. PROVISION OF PLASMA OR SERUM TO BE USED AS A BIOCHEMICAL CONTROL PREPARATION

Dr Maycock referred to the Note in brackets following the "Conclusions" of Para.2a. of Minutes, 22 March (page 4). He said he hoped RTDs would agree with the decision made after the previous meeting that a small group should prepare a paper in the first instance. He suggested and the meeting agreed that Drs Stratton, Bird and Jenkins should represent the RTD Meeting; the LDAG Quality Control Sub-Committee would also nominate 3 biochemists to the group and the Department would be represented by Dr Obank, Dr Maycock and Mr Cook.

Dr Rogers said that much larger quantities of plasma or serum might be needed than had so far been mentioned; one teaching hospital in his region used about 1.0L per week. If control preparations were supplied free of all charges, their consumption might increase even more. He had heard discussed a possible annual increment of 10-15 per cent in the use of these reagents. He hoped the ad hoc group would keep future consumption very much in mind.

Dr Bowley said he was not satisfied with the information given by the Department regarding the approach to a commercial firm and felt that the

Department had not been entirely open about the whole matter.

Mr Walters said that Supply Division proposed to invite tenders from a number of firms if it were decided that control sera should be prepared by a commercial firm.

Dr Macdonald said that the Scottish RTDs had the same reservations as their English colleagues about the provision of plasma or serum for this purpose.

b. NOTES ON TRANSFUSION

1. PRESENTATION

The meeting agreed that the revised text should be published as quickly as possible and that its presentation should be made as attractive as possible, for example on the lines of "Prescribers' Journal". It was suggested that the cover should be white with the title "Notes on Transfusion" in red lettering and the words "Revised 1972" in black.

2. TEXT

a. SUBZERO STORAGE TEMPERATURE FOR CRYOPRECIPITATE, GROUPING SERA ETC.

Dr Maycock mentioned that in the European Pharmacopoeia the recommended temperature would be - 30°C or lower. From discussion it was evident that few centres had subzero storage capacity at this temperature; it was agreed that as equipment was renewed, the opportunity should be taken to instal refrigerator cabinets at - 30° or lower. Mr Hanson undertook to consult PHLS which had recently ordered refrigerator cabinets which operated at - 40°C.

It was agreed that reference to subzero storage in the revised text should be "preferably - 25°C or lower".

b. VOLUME OF DONATION OF CITRATED BLOOD (see para.2f below).

c. PSEUDOCHOLINESTERASE

Dr Bowley and Colonel Field said they heard of about 5 cases a year in which the use of muscle relaxants caused paralysis in patients with a

congenital deficiency of pseudocholinesterase. The transfusion of blood or reconstituted dried plasma immediately corrected the position. Previous editions had not referred to the use of blood or plasma for this purpose. Neither albumin nor plasma protein solution contained pseudocholinesterase, and it was agreed that this should be mentioned in the revised text.

c. PROCEDURE IN THE EVENT OF AN RTC BEING PUT OUT OF ACTION

Dr Stratton said he had now received all the replies to his questionnaire and would prepare a paper for discussion at the next meeting.

d. PLASMA FOR THE PREPARATION OF SPECIFIC IMMUNOGLOBULINS

Dr Maycock referred to the paper dated 8 May 1972 circulated before the meeting, which showed some RTCs were now contributing more plasma. There were, however, still some which contributed little or none. Cambridge was a centre which from contributing very little had since the beginning of 1972 raised its contributions very noticeably. Dr Darnborough said this had been achieved by impressing the need upon team doctors and staff: he mentioned in particular PVP plasma from recently vaccinated staff of units such as hospitals.

ANTI-TETANUS PLASMA was difficult to obtain and arrangements similar to those at RTC Edgware might have to be made in other centres.

ANTI-CHICKENPOX OR HERPES ZOSTER PLASMA. The members of the meeting confirmed that as far as they knew herpes zoster patients in UK were mainly domiciliary patients, unlike in USA where they were usually in the care of consultant dermatologists, through whom they could be contacted.

ANTI-AUSTRALIA ANTIGEN PLASMA. This had been contributed mainly by RTC Edgware. All centres should be able to assist, unless there was some unexpected distribution of individuals with antibody.

Dr Maycock reported that a letter asking for the co-operation of GP's in recruiting donors of antibody plasma was about to appear in the journal of RCGP.

e. DONOR RECORD CARDS AND COMPUTERIZATION

i. Mr Walters reported that the Department was preparing a standard form for use in requesting transfer of particulars of a donor from one Centre to another, and that a paper had been prepared for the last meeting of Regional Donor Organisers on the definition of "Estimated Effective Civilian Donor Panel", one of the figures which appears in the quarterly and annual NBTS statistics.

ii. COMPUTERIZATION

Mr Walters reported that the Department had now received a summary of Mr Kiley's paper which was short and did not contain any revolutionary proposals. He also mentioned the helpful meeting, arranged by Dr Bird, at the RTC Birmingham on the 8 May, at which the computer programmes in use at Birmingham and Manchester had been discussed by those concerned in the work at these centres. Dr Bird explained that this was a preliminary discussion and that he thought an open meeting would be profitable.

Mr Walters said that a meeting was to be held in the Department to discuss Mr Kiley's paper and that this meeting would consider the comparative costs of operating the donor records department by computer and by the manual system. Dr Stratton pointed out that the systems in Birmingham and Manchester differed in that the former dealt with ordinary sessions and the latter only with two daily sessions held in the centre itself. Comparisons might, therefore, not be entirely straightforward.

A central computer for NBTS was not recommended in Mr Kiley's report.

Dr Drummond expressed the view that for each donor there should be a written or typed record containing all particulars from the time of his recruitment to his retirement.

It was agreed that a paper should be prepared and circulated to RTDs after the office meeting in the Department in July and that a special meeting on computerisation should, if necessary, be held.

f. ANTICOAGULANT SOLUTIONS

1. Dr Maycock reported that the EP Group of Experts concerned with blood and blood products had not accepted Dr Bowley's suggestion made at the meeting of 22 March that the standard donation should be 425 ml of blood mixed with 75 ml anticoagulant.

2. STANDARD DONATION

He said that the EP monograph would probably contain:-

i. The NIH ACD formulations A and B, containing trisodium citrate, citric acid and dextrose.

ii. Two corresponding ACD formulations containing disodium citrate and dextrose, based upon the Loutit-Mollison anticoagulant solution in BP in which a range of 2.0 to 2.5g disodium citrate is recommended for a donation of 420 ml blood. The upper concentration of citrate in the proposed EP formulation corresponded to the 2.5g in the BP range.

iii. The NIH CPD formulation.

In each of these the volume of anticoagulant required would be related to 100 ml blood. In the case of small volume ACD formulations, the volume would be 15 ml per 100 ml blood. In the case of CPD solutions the volume would be 14 ml per 100 ml blood. These formulations are set out in the copy of the draft EP monographs, distributed at the meeting on 22 March 1972.

The meeting was reluctant to increase the volume of the "standard" donation above 420 ml, because in addition to this amount of blood the donor already gave an appreciable additional volume in the form of specimens for various tests.

After further discussion it was agreed that the "standard" donation of blood should remain 420 ml and suggested that this volume of blood should be added to 75.0 ml ACD solution NIH formula A, an amount used in USA for a donation of 500 ml collected in a plastic container.

It was also agreed that the label on a plastics bag, containing 75 ml ACD NIH formula A, would carry a statement to the effect that the maximum amount of blood, for which the container was suitable, was 500 ml and that it would be left to RTDs to arrange to collect 420 ml. Dr Maycock undertook to consider this proposal with Supplies Division.

It was agreed that in the case of CPD solution, bags would have to contain the appropriate amount of the formula for a donation of 420 ml blood.

/ A mixture consisting of 420 ml blood and 75 ml NIH formula A acid citrate dextrose anticoagulant solution has a citrate concentration of 0.46g per cent which is the same as that of citrated blood consisting of a mixture of 420 ml blood and 120 ml Loutit-Mollison anticoagulant containing 2.5g disodium hydrogen citrate. /

3. AUSTRALIA (HEPATITIS-ASSOCIATED) ANTIGEN

a. REPORT OF ADVISORY COMMITTEE ON TESTING FOR THE PRESENCE OF AUSTRALIA (HEPATITIS-ASSOCIATED) ANTIGEN AND ITS ANTIBODY.

Dr Maycock reported that the Report of the Advisory Committee had been circulated under cover of HM(72)33 May 1972 and that he had arranged for Directors each to receive a copy.

b. TESTING OF DONATIONS

The position was:-

Testing all donations:	Sheffield, Edgware, Brentwood (since May 1972), Tooting, Wessex, Bristol, Cardiff (PHLS), Birmingham, Manchester including Lancaster, Liverpool.

Testing about half of all donations:	Newcastle (all in October), Cambridge (all in three to six months' time).
Testing less than half of all donations:	Leeds (all in June or July) Oxford: a Portakabin and equipment have been delivered and staff is being recruited. Meanwhile donations for certain uses (eg. in haemodialysis patients) are screened by PHLS.

Blood Products Laboratory had issued a list showing the regional reference numbers of Winchesters of plasma subsequent to which all Winchesters received at BPL had been tested for Australia antigen. Batches of dried plasma with later numbers were, therefore, prepared from Au-antigen tested plasma. BPL would gradually discontinue testing of plasma received from centres which were testing all donations.

c. ACCIDENTS

None had occurred in RTCs since the March meeting.

d. ANTI-AU IMMUNOGLOBULIN

The amount of material being received was reasonable. The proposed MRC trial had not yet started.

e. INCIDENCE OF AUSTRALIA ANTIGEN IN GENERAL AND OTHER POPULATIONS.

A paper prepared by Dr Darnborough had been distributed. This recorded an overall incidence of about 1/1500 antigen positive and 1/1300 antibody positive donors. No antigen or antibody positives were observed among 1449 forces donors (including USAF). On the other hand in two borstal institutions and two prisons antigen and antibody were detected in 1 in 488 donors (total tested, 976). Dr Darnborough was particularly concerned about the action that should be taken regarding donors associated with cases of serum hepatitis. Of 107 donations involved in 19 cases, the donors of 67 had been traced and tested (3 mos. to 2 yrs. later); four or 1 in 17 were positive. Among the 107 donors, the incidence of donors from prisons and borstals was the same as that among all donations collected, which might suggest that the risk attaching to blood

from such donors (normally bled only once) was not, in fact, higher than that from new general public donors. Dr Darnborough considered that the retirement of any donor, whether Au antigen positive or negative, and who was associated with a case of serum hepatitis, should be considered.

It was reported that RTC Edgware and all Scottish RTCs had discontinued collecting blood in prisons and borstal institutions. Dr Bowley, however, reported that the incidence in Sheffield region of antigen positives in new donors as compared with prisoners and inmates of borstal institutions was respectively 1/139 and 1/135. Dr Rogers reported corresponding figures of 1/250 and 1/285. Dr G H Tovey reported incidence of 1/541 (sample size 2164) and 1/486 in members of the Forces on the one hand and in prisoners and inmates of borstal institutions on the other. The corresponding figures from S. London were Nil (sample size 1451) and 1/285, and from Wessex 1/800 (sample size 2401) and 1/279.

In view of these discrepancies the meeting agreed that further information should be collected before it was decided to discontinue collecting blood in prisons and borstal institutions. It was also agreed that results should be reported in a uniform manner on a report form to be prepared and that Dr Cossart or Dr Zuckerman should be invited to talk about the specificity of reagents and antigen sub-types.

4. ANTI-D IMMUNOGLOBULIN

a. SUPPLIES OF PLASMA

It was reported that the amount of anti-D immunoglobulin was slowly increasing and the quality improving. No difficulty had been experienced regarding distribution which was running parallel to the expected number of cases.

b. BOOSTING AND DELIBERATE IMMUNIZATION

Dr Bowley distributed a questionnaire for completion by Directors who were

asked to send any comments on this to him within the next week.

Questionnaires should be completed by the end of June.

5. SUPPLY MATTERS

a. DISTRIBUTION OF PLASTIC TRANSFUSION GIVING SETS

The report of a group formed, at a previous meeting, to consider methods of distributing this equipment had been circulated. The group had met on 28 April and agreed to recommend that:

"The distribution of blood giving sets should no longer be the responsibility of Transfusion Directors and that the Department should take over this distribution responsibility with issues being made from central stores. This change of responsibility would in no way affect the Directors' responsibilities and rights

(a) regarding consultations etc on matters of design and other aspects and

(b) regarding support within their Regions to encourage the use of all approved sets".

Dr Maycock said that if distribution became the responsibility of central stores it was essential that the NBTS should always be consulted about matters concerning design and quality control which affected the use of the sets. If distribution from central stores should not prove feasible, RTDs might be asked to reassume responsibility for distribution.

In the discussion the following points were emphasized:

(a) If giving sets were distributed centrally it was essential to keep at least two, preferably three, makes of set in use. Mrs. Tunnard and Mr. Hanson said they thought central supply would operate satisfactorily in this respect.

(b) That RTDs should be kept informed of any complaints arising from faults in design or quality of equipment. Dr Bowley suggested that such complaints should be channelled through RTDs. Dr G H Tovey suggested that close collaboration between Supply Division, Regional Supply Officers and RTDs would achieve this object. Mrs Tunnard and Mr Hanson agreed to consider this matter.

The meeting agreed to accept the recommendation of the group. The change could not take place before December 1972 or January 1973; RTDs agreed to maintain the present method of distribution meanwhile. Arrangements would have to be made to run down stocks of sets in RTCs and to build up stocks in central stores.

(c) REDESIGNED GIVING SET

(i) Mr Hanson reported that it was expected that sufficient sets would be available in August to distribute 150 of each make to each region.

(ii) It was felt that the Sub-Committee which had been formed to consider the redesign of sets in relation to the various plastic containers should complete their work on the new piercing device and that any subsequent proposals regarding plastic equipment should be dealt with by the Blood and Blood Products Equipment Sub-Committee.

(d)"LITTLE SISTER" AUTOCLAVE

The adverse report referred to previously by Dr Bowley was being investigated. He was asked, if possible, to supply further information.

6. USE OF FRESH BLOOD FOR THE PREPARATION OF FRESH FROZEN PLASMA AND CRYOPRECIPITATE

A confidential paper prepared from paras.12 and 13 of the monthly reports and distributed before the meeting showed the numbers of donations used for preparing fresh frozen plasma and cryoprecipitate in the period October to December 1971.

There were considerable regional differences in the number of donations per 10,000 population used for making these two preparations: 1-10 donations /100,000 - Leeds, Sheffield, Cambridge, Brentwood, Tooting, Birmingham and Manchester; 11-20 - Newcastle, Wessex, Bristol, Cardiff, Liverpool; 21-30 - Edgware; 30 and above - Oxford.

The main reasons for these differences were probably: preference on the part of haemophiliacs to be treated at certain medical units; specialization at certain medical units; presence of concentrations of haemophiliacs in certain places eg. at Alton; lack of facilities for preparing cryoprecipitate.

The meeting was unwilling that the regional figures should be given to Dr R Biggs but was willing for the totals to be used to answer a questionnaire received by Dr Maycock from the World Haemophilia Federation.

7. LEUCOCYTE-POOR BLOOD

Dr Darnborough said he had been asked, if possible, to supply leucocyte-poor blood for renal transplant patients. He was reluctant to do so but was being pressed to give an answer and asked for the views of the meeting.

Dr G H Tovey said that it was generally agreed that the case for using this blood for these patients was now reasonably established.

Dr Maycock reported that Professor van Rood had recently stated that prospective transplant patients should be protected in every possible way from forming HLA antibodies and that ideally transfusion laboratories should assist by providing leucocyte and platelet poor blood, or washed concentrated red cells, or washed frozen red cells or, best of all, autologous blood which had been preserved frozen.

Dr G H Tovey said that RTC Bristol prepared leucocyte-poor blood for about 80 patients/qtr. RTCs. Leeds, Brentwood and Birmingham also provided leucocyte-poor blood. RTC Edgware was prepared to do so if asked. RTC Oxford had not received any requests.

Dr Maycook said that a much simpler method, than those at present available, of removing leucocytes was described by Engelfriet in an article to be published shortly in Vox Sanguinis. Centrifugation was still the only way to reduce the number of platelets.

It was agreed that Dr Obank and Dr Maycock should consider whether a special meeting should be arranged to determine policy and discuss arrangements for providing leucocyte-poor blood and the amounts likely to be needed.

8. MEDICAL LABORATORY TECHNICIANS: PRINCIPAL TECHNICIAN GRADE

Dr Maycock said he had been asked by several RTDs to put this subject on the agenda and that he had then written to all RTDs asking whether the grade had been introduced in any RTC and whether there was a prospect in any centre, of the grade being introduced within the next 5 years. The replies showed that there were no Principal Technicians in NBTS at present and that only 3 RTDs foresaw any prospect of introducing this grade in their Centres during the next 5 years. Many RTDs considered that the qualifying condition (staff establishment of 63 medical laboratory technicians) should be modified in the case of RTCs for several reasons:

a. technicians might, because of the nature of the work in certain departments, also be in charge of laboratory assistants and other unqualified staff;

b. an RTC was a regional reference centre, the head technician of which might frequently have to be in contact with Principal Technicians elsewhere in the region.

c. In certain pathology laboratories grouping of the medical laboratory technician staff allowed the qualifying figure of 63 to be achieved. This manipulation could not be done in NBTS.

Dr Obank said that it was expected that Principal Technicians would tend to carry more managerial duties and if the head technician of the RTC had to discuss transfusion matters, it would probably be with the Chief or Senior Chief Technician in charge of the hospital Haematology Department. It was never the intention, or expectation that every pathology laboratory or transfusion centre would eventually qualify for a Principal Technician. There would, in fact, be comparatively few such posts. He pointed out that when Whitley Council was discussing the introduction of this grade at least one member of staff side was from NBTS. It was permissible to count only medical laboratory technicians in the qualifying number of 63; laboratory assistants, laboratory aides etc.could not be included at the present time. The meeting asked that its views should be brought to the notice of Whitley Council.

9. DATE OF NEXT MEETING

This was arranged for Wednesday, 20 September 1972.