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AFFILIATED TO

NORTH OF SCOTLAND BLOOD TRANSFUSION SERVICE

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IAC/PA

6th November 1978

Dr. John D. Cash
Regional Director
Edinburgh and South-East Scotland
Blood Transfusion Service
Royal Infirmary
EDINBURGH, EH3 9HB

Dear John,

NATIONAL POLICY RE SCOPE OF HEPATITIS TESTING IN REGIONAL TRANSFUSION CENTRES

I am relieved to hear that the overdue meeting on Hepatitis is to be organised for a date in December. I wish to raise a topical point from this small Centre which is a source of friction with the Microbiologists and the Community Medicine Specialists.

Over three years ago we decided here, in the interests of health and safety and, secondly, on epidemiological grounds, that we would test every specimen appearing in the Transfusion Centre for HB_sAG by our current testing system. This was, initially, by the Das and Hopkins technique (H.I.) and, latterly, by Hepatest. Positive results were than rechecked by the Microbiology Department upstairs (Dr. H. Williams). We do not regard a positive result as being more than a screening test and we did not feel that we had a clinical duty or obligation on that first result to notify any of the clinicians or GP involved. The main difficulty that arose from this policy was that we were often testing patient samples up to seven to ten days after receipt as we normally do such testing in batches. The practical point is that donors are given priority in order to have blood labelled and ready for issue. As a result there were cases where the patient had either been operated on or a mother had been delivered and discharged from the hospital. When the confirmatory test was done in the Microbiology Department and 'phoned to the clinicians, the Control Infection System and the Community Medicine Specialists in the Highland Health Board started a routine investigation involving relatives and staff involved which was often quite extensive and naturally caused much distress and anxiety.

We have recently had a maternity case where the tube was received for ante-natal testing on Thursday, 21st September. This patient had been checked for HB_sAG some months before in the pregnancy and found to be negative. We did not regard this sample as urgent and as there was only one more working day that week we did not test the sample until Monday, 25th September when a positive result was found. The sample was taken by the Senior MLSO to the Microbiology Department that day but was, regrettably, placed in the wrong refrigerator by other staff and was not tested for a further ten days by which time the mother had been delivered in a Dingwall hospital where the maternity staff and the GP were unaware of the initial positive screening tests. Dr. Murchison now proposes to call a meeting to discuss this type of problem.

The point at issue is whether we should continue to screen patient samples.

/I feel

I feel that it is my duty to see that Hepatitis B Surface Antigen is excluded from the Transfusion Centre, not only in the interests of the staff at risk, but from the remote possibility of contamination of blood or blood products. I also feel that, regardless of the repercussions from finding a positive result in retrospect, the long term benefit to the public in the Community is surely served by detecting such cases who can then be investigated as well as their relatives. Surely one should welcome detecting carriers of an infectious disease, e.g. typhoid and paratyphoid. It may be that SHHD may have to make a ruling as to how extensive Hepatitis screening should be but I would welcome the views of your good self and my colleagues prior to the meeting in December at which the matter can, no doubt, be discussed further if you feel a place on the Agenda is merited.

With kind regards,

Yours sincerely,

GRO-C

Dr. Iain A. Cook
Regional Director

cc Directors
Miss Morag Corrie