NOT FOR PUBLICATION

1st MEETING

ADVISORY GROUP ON HEPATITIS

MINUTES OF MEETING HELD ON 3 OCTOBER 1980

The following members were present:

Sir Robert Williams	(Chairman)
Dr G W G Bird	
Dr D M S Dane	
Dr W J Jenkins	
Prof A C Kennedy	
Dr R Lane	
Dr S Polakoff	
Dr S E J Young	
Miss C Sowerby	Acting Secretary
Dr M Sibellas	Medical Secretary
Dr E L Harris)	
Dr T Geffen)	
Dr D Walford)	DHSS
Dr H M Hughes)	
Mr R Tringham)	
Dr G I Forbes	Scottish Home and Health Department
Dr R Logan	Northern Ireland

1. Apologies for absence

Apologies were received from Dr Flewett, Dr Lovett, Dr Roger Williams Professor Zuckerman, Mr Jones and Mrs Dawar.

2. Introduction - Paper 1

The Chairman welcomed members and explained the reasons for the formation of the Advisory Group. Dr Harris thanked members for agreeing to serve and explained that the terms of reference had been left deliberately broad. The Chairman said that the Group would discuss hepatitis generally and exchange ideas. The terms of reference were agreed.

3. Hepatitis B risks to staff - Paper 2

(a) Occupational groups at risk

Dr Polakoff introduced her paper which summarised the evidence available in the United Kingdom and abroad. The groups at most risk were those whose work involved contact with blood, for example staff in dialysis units. Carriage rates found in surgeons, pathologists and dentists were about five times higher than in control groups. Dr Lane suggested that any groups who were continuously and heavily exposed to blood might be offered immunoglobulin routinely as was the case at the Blood Products Laboratory which had no recorded cases of the disease.

Dr Polakoff referred to reports of Hepatitis B since 1972. There was no evidence of increasing incidence and the numbers appeared to be stabilising. Estimates of the annual attack rates in individual groups of health service workers were:-

Physicians (including GPs and hospital doctors)	19 per 100,000
Surgeons (including gynaecologists)	27 " "
Laboratory workers (including technicians)	20 " "
Nurses	9 " "
Dentists (very approximately)	16 " "

These figures did not allow for under-reporting and also took no account of the base line population experience.

Accident advice and protection

It was agreed that there were no good indications for the regular or frequent testing of mentally subnormal children. Staff should be given advice as to the dangers of accidents and the action which should be taken if they occurred.

Dr Lane referred to trials that had been carried out on mothers carrying the e antigen. It was thought that hepatitis B immunoglobulin would protect the babies for only about a year. It was agreed that further trials would be useful.

Working guide for use of Hepatitis B specific immunoglobulin

Dr Lane advised that 1,000 grams of immunoglobulin was the maximum that could be produced by the Blood Products Laboratory per annum. This was sufficient to meet current demands with the 2-dose schedule.

Dr Lane said that all products should be accompanied by a manufacturers data sheet and that he would be prepared to accept the PHLS paper for this purpose. The Chairman agreed that the paper could be used as a guideline subject to the modification of the section referring to babies. The supplies situation should be kept under tight control and immunoglobulin given only to people in real need.

(b) Rosenheim Report page 25, para 6.5

Dr Dane spoke to this item and recommended that screening should be carried out only in the event of a surgical mishap. It was agreed that advice in paragraph 6.5 could be used provided that the sentence "They should subsequently be screened for evidence of infection" was omitted from any future DHSS advice.

Report of the Expert Group on Hepatitis in Dentistry

Mr Hughes spoke to this Report. He said that it had been well received in the field. Area Dental Officers had been helpful in obtaining treatment for known carriers and the question now was what further action should follow the Report.

Dr Dane asked whether Dental Schools should screen the staff of clinics for hepatitis B antibody. The Patients Association was interested in this subject and had reported that some London hospitals were reluctant to undertake routine dental work on known hepatitis B carriers.

4. Hepatitis risks to patients from staff

a. Acute Hepatitis B associated with gynaecological surgery (Paper 5)

Dr Polakoff reported on the article. It was the first account from the United Kingdom of an incident where a surgeon had infected patients. Dr Dane referred to the problem of the long term e antigen carrier and the difficulties a surgeon could experience if he wished to return to his chosen speciality.

b. Guidelines to Health Authorities on Hepatitis B carriers

The Chairman asked whether the advice in CMO 25/72 referring to hepatitis B carriers among staff, was still applicable in 1980/81. Should exclusions apply only to carriers who have infected others?

Dr Jenkins considered that the risk in Blood Transfusion Units was small as very little open processing was now practised but regular screening was desirable to ensure that staff had not become infected. He would have no objection to the employment of carriers except where open systems were in use. In general it was considered that the only action that needed to be taken on discovery of HBs Ag carriage by a member of staff who had not been the source of infection, was to give guidance on hygiene and that there was no call to restrict professional activities. It was, however, agreed that special attention should be given to e antigen carriers even if they had not been shown to be the source of an epidemic and that all carriers should be excluded from renal units. In considering the case of a gynaecologist who had been responsible for infections, it was agreed that such an individual could reasonably be involved in family planning, but should not insert IUDs, nor perform vasectomies. It was agreed that a draft circular would be prepared for approval at the next meeting.

Dr Sibellas asked if members wished to update HC(76)13 referring to the prescription of hepatitis as an industrial disease. Enquiries had been received from teachers of the mentally subnormal and for a definition of an "accident". It was agreed that the circular was still valid but could later be reviewed in general terms.

c. PHLS surveillance

Dr Polakoff presented a provisional report on the first 6 months' results of a survey to look for clusters of patients who might have been associated with a particular hospital. There had been 419 cases reported but the results so far revealed no evidence of clustering attributable to a common source of infection in hospital.

5. The Significance of Hepatitis B 'e' antigen (HBe) and its antibody (anti-HBe) Paper 8

Dr Dane introduced his paper and described RIA and ELISA tests to detect carriers. It was agreed that the systems should be more widely available through the PHLS.

6. Developments on laboratory testing for the presence of Hepatitis B antigen and its antibody

Dr Jenkins said that the Advisory Group on Testing for Hepatitis B Surface Antigen and its Antibody had been reconvened in 1978 to revise the Second Report. Five meetings had been held and a Third Report prepared. This had not been formally approved by the Group so copies could not be made available to members but would be circulated before the next meeting. He summarised the new recommendations as follows:

i. All donations destined to contribute to protein fractionation at NHS Fractionation Centres should be tested by techniques with a sensitivity of at least 2 BSU/ml of HBsAg.

ii. The British Standard of HBsAg should be made available by the National Institute of Biological Standard and Control only to laboratories familiar with safety aspects of testing for HBsAg.

iii. The Division for Microbiological Reagents and Quality Control of the Central Public Health Laboratory Service, should continue to distribute self assessment panels of known HBsAg positive samples. Regional Transfusion Centres should make available any low titre HBsAg positive donations for this purpose.

iv. All Regional Transfusion Centres should screen as many new donors as possible for anti-HBs. Panels of suitable anti-HBs donors should be built up.

v. NHS Fractionation Centres should issue an appropriate minimum standard anti-HBs serum to Regional Transfusion Centres.

vi. Regional Transfusion Centres should now undertake their own confirmation tests as a preliminary to sending confirmed positives to reference centres for more detailed analysis.

vii. There should be no general screening of donations for anti-HBc. Donors implicated in cases of post transfusion hepatitis should be comprehensively tested at reference centres.

viii. Liver function tests should not be used for general screening of blood donors.

ix. Hospitals should be encouraged to report all cases of post transfusion jaundice and where these could be due to non-A, non-B hepatitis, the facts should be

reported to the appropriate Adviser in Blood Transfusion at the DHSS or SHHD.

x. Research should be undertaken in the United Kingdom to determine the extent and severity of post-transfusion hepatitis due to non-A, non-B hepatitis viruses.

xi. A Committee of experts should be established to assess the suitability of any new tests for hepatitis markers.

xii. The National Blood Transfusion Service should set up its own training programme for staff engaged in HBsAg testing. Such programmes are best organised by the NHS Fractionation Centres.

The Chairman said that it had been suggested that the Advisory Group on Testing for the Presence of Hepatitis B Surface Antigen and its Antibody should become a sub-committee of the present Group. It would be necessary to appoint a chairman of any new sub-committee as Dr Jenkins was retiring and it was agreed that the whole matter would be covered more fully at the next meeting.

Dr Walford reported that Blood Products Laboratory material for an R I A test for HBsAg was ready for distribution but representations had been received from manufacturers complaining of unfair competition that could affect their home and overeseas markets, and the matter was under active consideration.

7. Hepatitis B Immunoglobulin

a. Supplies

Dr Lane said that he would prefer to leave discussion on this topic until a decision on use and distribution had been made. He suggested that a small group meeting should be arranged to consider production of new material, distribution and dosage. It was agreed that the subject would be considered fully at the next meeting.

b. Distribution Paper 10

Dr Polakoff spoke to this paper. She commented that she had not experienced difficulty in getting immunoglobulin to accident victims. It was despatched immediately on receipt of a telephone message. If the immunoglobulin was not required it was speedily returned to her.

8. Consideration of topics for second meeting

It was agreed that the following items might be considered:-

(i) transmission of Hepatitis B via medical equipment
(ii) present position of hepatitis vaccines
(iii) possible downgrading of hepatitis B virus in laboratories from Howie Code category B_2 to C.
(iv) Certain nursing aspects in the Rosenheim Report
(v) Possible occupational risks from home dialysis units.

9. Date of next meeting

This has now been fixed for Friday 5 December at 10.30 in Room 67, Hannibal House.