

Dr G A Scott

Dr A D McIntyre

Dr A T B Moir

Dr A B Young

Dr G Gilray

Dr G I Forbes

Dr A E Bell

Mr E Redmond (Official file)

Mr Kealey

*I have no doubt we should be associated with this group by a member & an absence of records.*

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INFECTIOUS HEPATITIS IN NHS STAFF

I attended a meeting in London on 12 February (papers appended) chaired by Sir Henry Yellowlees. In addition to Departmental representatives Sir Robert Williams and Dr Polakoff of PHLS were also present.

Sir Henry began the meeting by saying that this was an office meeting called to discuss (a) the day to day hazard to staff from patients who are Hepatitis B surface antigen positive and (b) the hazard to patients treated by members of staff who were HB<sub>s</sub>Ag positive. He then referred to a recent incident where 7 cases of Hepatitis B had been linked with operative treatment undertaken by a senior registrar in obstetrics and gynaecology. He called upon Sir Robert Williams to comment.

Sir Robert said that for some time he and his colleagues in PHLS had been on the look out for such an incident occurring either in this country or elsewhere but up till recently there had been only two or three reports of health care staff infecting patient anywhere in the world. In this country the carrier rate for HB<sub>s</sub>Ag in medical and allied staff was 5 - 10% above that in the rest of the population where about 1% were HB<sub>s</sub>Ag positive. He and his colleagues had tried to mount a study on staff but had eventually abandoned it because of staff relation problems. Staff were reluctant to participate because if they were found to be HB<sub>s</sub>Ag positive it might prejudice their future employment. The risk was small but this recent event indicated that it could not be dismissed.

Sir Robert then went on to say that new virological techniques gave an opportunity to detect those more virulent carriers by the identification of the E antigen, but this technique however was not yet perfect or foolproof. He estimated that perhaps one in 10,000 of the hospital population might carry the E antigen and pointed out that there was a turnover of carriers.

He then went on to review the usefulness of pre-employment testing for HB<sub>s</sub>Ag and indicated that this would perhaps give a base line for the employee but would not protect the patient. He considered that if there was routine testing for HB<sub>s</sub>Ag staff would be less and less willing to look after patients who were HB<sub>s</sub>Ag positive.

Sir Robert was of the opinion that this recent incident had indicated the need for better surveillance of Hepatitis B and the possibility of geographical clustering should always be considered. This could now be done through CDSC.

It was likely when the report of this most recent incident was published many members of the profession and public would be disturbed and the profession would be far more conscious of the problem.

Dr Polakoff said that the registrar in question was found to have infected only patients on whom major surgery had been performed. No cases had been found in obstetric patients even those having caesarian sections. This was of great interest and very reassuring. During the discussion which followed it was observed that it was not uncommon for surgeons to puncture their gloves when operating.

Dr Geffen wondered if this is a one-off situation but Sir Henry felt we did not know enough yet and the incident demonstrated the need for an effective surveillance system though it was unlikely that many had escaped the net as in the past Hepatitis B cases had been picked up which related to tattooists and acupuncturists but this was the first from an NHS source although we had known of the risk for at least 10 years. He considered that the view being expressed seemed to be against entry screening or routine screening of staff at any interval apart from those at special risk eg dialysis units. If one goes into hospital then this was just one of the risks that one took. Many medical procedures have a risk eg general anaesthesia. There was need for public and professional education on the problem and methods of accomplishing this would be considered by the Department. He reiterated the need for an effective surveillance system. All Hepatitis B should be reported to CDSC.

Sir Robert Williams said that a new reporting form would be required with a specific question asking whether the patient had a surgical operation or dental treatment recently.

It was pointed out that none of the cases attributable to this senior registrar had been reported to the MOEH and the reporting mechanism would have to be tightened.

Dr Abrams stated he had seen the senior registrar concerned and on a staff relations basis they had agreed to treat him generously. The Department had arranged that he was kept in employment and had undertaken to arrange his retraining if this became necessary.

Sir Henry indicated that under circumstances such as this staff should know that they would be generously treated.

The Committee then went on to discuss the second aspect of the problem - the risk to health care staff exposed to patients who are HB<sub>s</sub>Ag positive. I recounted the recent Scottish experience and indicated that there was need for advice to Health Boards. The problem arose both in respect of acute trauma and in the management of long term patients in mental hospitals.

Sir Robert Williams was of the opinion that in any major accident where there was likely to be the exchange of blood then immunoglobulin was required though he confessed that there was a need to quantify the likely demand. He indicated that PHLS had issued guidelines to area health authorities in England and this covered both the acute incident and the problem relating to mental deficiency institutions.

Dr Harris pointed out that after the publication of the report on this incident the demand for immunoglobulin would shoot up. Consideration should also be given to the load on laboratories if as a consequence there was an increase in requests for testing for HB<sub>s</sub>Ag.

Dr Evans said that it was apparent that there was need for clear advice to the profession on all aspects of the problem of Hepatitis B and suggested that a memorandum similar to that produced for smallpox and Lassa fever should be prepared. Sir Henry accepted the proposal and it was agreed that an expert group should be established to prepare the memorandum.

I consider that it would be useful if Scotland were represented on this group although we were not represented on the groups which prepared the smallpox, Lassa fever or rabies memorandum for DHSS but merely commented on the DHSS drafts.

GRO-C

WILLIAM M PRENTICE  
16 February 1979.

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