Minutes of Meeting between Blood Transfusion Services of England and Scotland and the CJD Surveillance Unit

Board Room SNBTS HQ

5 May 1998

Present:	Dr R Will	CJD Surveillance Unit	(RW)
	Prof. I M Franklin	NMSD SNBTS	(IMF)
	Dr J Metters	Deputy Chief Medical Officer DoH	(JM)
	Dr P Hewitt	Consultant in Transfusion Medicine NBA (representing Dr Robinson)	(PH)
	Dr T Snape	Production Director BPL	(TS)
	Dr A Keel	Medical Dept.Scottish Office	(AK)
	Dr R Perry	Director PFC	(RJP)

Meeting began by accepting the provisional agenda provided by Dr Will. JM suggested that an additional item on regulatory affairs in Europe should be added and it was agreed that this would be discussed as item 2 after nvCJD.

1. new variant CJD (nvCJD)

a) *current status*

RW updated the meeting on the current status of patients with nvCJD. There were 23 confirmed and one highly probable case, all of whom were now deceased. JM pointed out that the highly probable should be included, for reasons of clarity, with the confirmed cases and it was acknowledged that there were 24 confirmed cases. At present there are a number of strongly suspected cases but none of these were believed to be blood donors.

There was some discussion about the situation in Europe in particular with regard to the case in France. RW confirmed that there was no definitive evidence that this individual had been injecting non-prescription drugs and that the aetiology was therefore unclear.

It was agreed that there was a requirement to define "strongly suspected" and that this issue had been discussed recently at EMEA. RW pointed out the young patients referred to the CJD surveillance unit (CJD SU) under the age of 50 years would turn out in the majority (6/7) not to have nvCJD. A definitive diagnosis is not usual in life unless the person has a brain biopsy, although even then a negative biopsy may prove to be false. Clearly a positive biopsy is defining.

b) *Definition of "Strongly Suspected"*

The definition of strongly suspected was then discussed and RW agreed to provide the CJD SU written criteria currently in existence. He did however point out that these criteria will probably change with time

as new investigations or further knowledge is gained. At present however the criteria were as follows:-

i) neuro-psychiatric disorder with progression to neurological signs
ii) exclusion of alternative diagnoses
iii) no prior history of iatrogenic CJD risk
iv) positive clinical features (require 5 of 6 of these which include involuntary movements, dementia and ataxia). RW pointed out however that the definitions for meeting these positive clinical features could be made hard or soft as was required.
v) investigations: this includes 1433 immuno-assay in CSF and a positive MRI showing a high signal in the posteria thalamic area.
vi) tonsillar biopsy is being considered but is not being included at the present time by the EMEA).

TS asked about the time scale of proceeding from possible to strongly suspected to definite. RW commented that the time from first symptoms to seeing a neurologist is in the order of 6 months, there then follows a further short delay prior to referral to the CJD SU. However the CJD SU assessments do not always come up with a positive result initially and repeated visits may be required before they do. It was agreed that the intervals between presentation and being strongly suspected or definite would be important if it was possible to take individual donations out of unfractionated plasma pools. RW did state that the great majority of definite cases will have been through "probable" phase. With the regard to the precise wording it was agreed that the CPMP statement should be provided with the minutes of the meeting.

There was then a discussion about how to cope with media reports of cases, proven or suspected, of nvCJD. After some discussion it was decided that the UK Blood Transfusion Services must only act on information received from the CJD SU in terms of definite or strongly suspected cases. However it was agreed that as good medical practice it was possible for UK Transfusion Services to ask the CJD SU specifically about a particular media case and seek confirmation or denial as to the likelihood of them being a blood donor. There was some further discussion on action to be taken on possible (ie not yet strongly suspected) but it was decided because the number of these cases was large and the time taken to resolve the issue of the possibles made this impractical.

c) *Procedures for notification*

RW stated that he understood the CJD SU is to inform the relevant authority in the country were the patient was resident. This is the current legal position and JM confirmed this. RW went on to state that the full residential history (and educational re universities) was taken and it was agreed that CJD SU would notify each country in which the person with strongly suspected or proven nvCJD had lived. It was JM's view that notification to all countries was not appropriate. However all

cases of nvCJD must be notified to the country or countries where the person has been resident.

JM expressed some concern at how the UK was to identify its own citizens who may have donated blood abroad. RW confirmed the CJD SU would indeed notify overseas authorities of such cases of which they were aware (and there had been such a case).

Consent

RW confirmed that he would wish to obtain consent to notify a third party (e.g. UK BTS). Nevertheless he acknowledged that this was dependent upon consent being forthcoming and the CJD SU had not reached a definite view about what to do if consent was refused. IMF pointed out that there was a problem for Blood Transfusion Services who were required to withdraw products from strongly suspected or confirmed cases and yet the issue of family consent may override this. JM expressed the view that in England consent (or its denial) by relatives probably does not enjoy the force of law since relatives cannot give consent for or on behalf of an adult. It would also be possible to use the principle of "in the interests of the public health" and inform relatives that the notification of blood services will be done. It was therefore agreed that RW would amend the protocol\ethics committee form to include the requirement to notify blood services, that the family would be informed that such notification would take place but would not be asked to give their consent for such notification.

d) *Procedures for Identification of Recipients of Blood or Blood Products Derived from nvCJD Donations.*

It was acknowledged that notifications of prior blood transfusions to patients who develop nvCJD or classical CJD was already part of the epidemiological review exercise.

At this point the proposed notification system and form designed by PH were discussed. The following amendments were proposed:-

- need only two boxes for strongly suspected and confirmed cases
- boxes are required for each country of residence so that these may be ticked
- add "FOR IMMEDIATE ACTION" to the top of the form
- add the MCA (Frances Rotblat) to the anonymised communication list and it was agreed also that all UK health departments should be provided this information on all cases (anonymised).

The precise means of communication would be a telephone call to the relevant National Medical Director (or their medical deputy), followed by a faxed transmission of the form to the Medical Director's office (or deputy). All other communications would go by first class post.

It was agreed that RW would provide a written protocol for notification (in the form of a standard operating procedure) for the CJD SU.

e) *Identification of Recipients of Blood from nvCJD Donations*

RW would like a procedure for identification for such recipients because these would be the most likely to show any infectivity if blood products were implicated.

After some general discussion it was realised that the issues related to the identification to the donor level for labile products and for plasma products, and that the issue of informing recipients specifically was a separate one not for this group.

It was agreed that in the UK if the Transfusion Services were informed of a donor with nvCJD then recipients of all labile products would be identified.
The next issue was then who should hold the information. It was agreed that this should be held by the CJD SU, with regard to all information from such recipients within the UK. In this way they would be in a position to marry up recipients with patients in future years. Again it was evident that there was a need for a clear standard operating procedure for the Blood Transfusion Services to identify these recipients and notify them to CJD SU. JM again felt that "the public good" issues should be sufficient to deal with concerns over data protection.

TS made the point of what one should do if these recipients are continuing to be blood donors. It was agreed that although it was an interesting and important question this was already being addressed by MSBT and SEAC.

At present plasma product recipients from a batch in which there is a donation from a nvCJD case are not being traced for logistic reasons. There is post marketing surveillance of plasma products in Scotland plus the questioning of patients and relatives regarding transfusion recipient history would provide some information. Patient interest groups such as the Haemophilia Society are also setting up systems of formal surveillance. Another problematic area, in addition to the large numbers of patients who receive single doses of albumin as excipient in vaccines, etc., is that most of the record keeping for the administration of these plasma products is outwith the control of the UK Blood Services.

2. REGULATORY SYSTEM

In general discussion it was acknowledged that the European commission remained somewhat suspicious over the UK attitude over TSEs following the BSEs handling. It had recently been agreed that all countries which have received batches of product containing a donation from a donor with nvCJD would be notified to the relevant authorities in the countries concerned, ideally through the MCA rapid alert system.

RW confirmed that the CJD SU was in contact with other similar surveillance units in the rest of Europe. Again there was general agreement that the UK Blood Services must adhere to European rules unless they decide to adopt more stringent criteria in which case the UK must advise the Commission.

There was some discussion about the Director General 24 (DG24) and its watch dog role over other areas of the European Commission, especially DG3 (this deals with pharmaceuticals and includes the EMEA). DG24 was set up as a defence against criticism of the European Commission for not regulating its own affairs.

3. CLASSICAL CJD

RW stated that at present it will not being informing UK Transfusion Services about classical CJD on the basis that we would not withdraw products. TS expressed some concern in that BPL would wish to exclude from fractionation any units still not pooled but would not withdraw product.

JM pointed out that the CPMP view is that classical CJD is not a reason for recall. It was felt that the UK Transfusion Services should not lend support to those who might wish to institute such recalls and there is a feeling that in the US there was a wish to back track from this because of the major problems in plasma products supply that had arisen. However it was agreed that as a matter of good medical practice, CJD SU would inform UK Transfusion Services medical directors of any very recent donations from a person who is diagnosed has having classical CJD (ie within 12 months).

The current status of the lookback was discussed. PH explained the study looking at donors, following the fate of their donations and the fate of recipients. The classic CJD cases was the second part of the study looking at cases who had actually received products and then proceeding to identify donations. However it had rapidly become clear that this study could only go back as far as the Blood Transfusion Services were able to go back in their records since there is little point in identifying donations in hospital if these could not be tied in with a specific donor. IMF asked what the original aims of the study had been and what was its statistical power. Since at at the outset it had been unclear what the number of patients involved would be this had not been factored in but JM suggested that the UK Transfusion Services should collate the data so far, write up an interim report and return to the DoH and Scottish Office and ask if they wish to continue the study and provide funding for it. It was agreed that RW and PH would action this aspect.

4. CRITERIA FOR DONOR EXCLUSION

RW asked if dura mater implants was an exclusion criteria and IMF confirmed that brain surgery or spinal surgery prior to 1993 was now an exclusion. There was some discussion as to the validity of using a cut off date in 1993 by JM and IMF agreed to go and explore the reasoning behind this. (Note added after the meeting; The date of 1993 complies with the advice of the UKTSs and NIBSC Executive Committee advice in this regard).

In the NBA an information leaflet is provided to deferred donors who have a family history of classical CJD or have had prior brain or spinal cord surgery. There was a feeling that there was a need to identify the counselling procedures since the CJD SU had received a number of telephone calls from worried individuals who have been deferred for these reasons.

RW expressed his concern that a family history of classical or nvCJD excludes some individuals who have no greater risk of developing this disorder. He cited one case where a brother of an index case had been tested and found to have the normal PrP gene and therefore was not at risk. JM confirmed that the current deferral advice comes from MSBT and is therefore a statutory and not a professional issue. IMF gave his view that the UK Transfusion Services can only use absolute objective criteria in donor deferral rather than a case by case opinion.

There being no additional business the meeting closed at 12 noon.

HEALTH CHECK (Medical - In confidence)

FOR YOUR INFORMATION

Donors should leave at least 12 weeks between donations

New Donors should be aged between 17 and 60, be in good health and weigh over 50 kg (7st 12lb)

In the unlikely event that your blood is confirmed to be positive in any test you will be contacted and given medical advice. If you would like to know more about the tests carried out on your blood, please ask us.

Remember you can't get hepatitis, HIV or any viral infection by giving blood.

HELP US KEEP BLOOD TRANSFUSION SAFE

Never give blood just to get a test. If you do, you risk infecting other people.

If at any time after you have given blood you have doubts about whether your donation should be used - please let us know

If you are worried about HIV or hepatitis you can talk to

- the nurse or doctor at the session
- your GP
- national AIDS helpline: freephone 0800 567123 (24 hour service)

It is quite all right to leave the session without giving blood and with no questions asked.

If you suffer an illness within 14 days of giving blood, it may affect your donation. Please let us know

ALL DONORS	Yes	No
1. Are you fit and well?		
2. .Are you seeing a doctor or other health care professional?		
3. Are you having treatment of any kind?		
4. Have you been told you should **never** give blood?		
5. Have you taken any medication including over the counter remedies such as aspirin **in the past five days?**		
6. Do you work for the emergency services; drive an HGV, bus or train; or will you be working at hazardous depths or heights in the next 24 hours?		
7. Do you take part in any hazardous hobbies diving, flying or motor racing?		
8. What is your occupation?		
9. Has anyone in your family had CJD **(Creutzfeldt-Jakob Disease)**?		
10. Before 1993 did you have any brain surgery or operation for a tumour or a cyst on your spine?		
IN THE PAST 4 WEEKS have you:		
11. had contact with any infectious disease?		
12. had any vaccinations or immunizations?		
IN THE LAST YEAR have you		
13. received blood yourself?		
14. had acupuncture, ear/body piercing, a tattoo c semi-permanent make up?		
15. had an injury which may have put you at risk of acquiring hepatitis or HIV? (e.g. a jag from a needle)		
WOMEN only		
16. Are you pregnant or have you a child under 1 year ?		

SINCE YOU LAST GAVE BLOOD have you		
17. had surgery or a serious illness ?		
18. travelled or lived outside western Europe, USA or Canada? If so, where		
19. Have you had a fever while abroad, or shortly after your return to the UK?		

FIRST TIME AND DONORS WHO HAVE NOT GIVEN FOR 2 YEARS	Yes	No
20. Have you ever had a serious illness?		
21 Have you ever had any operations?		
22. Do you suffer from **chest pain, breathlessness, asthma, high blood pressure, diabetes** or **epilepsy** (fits)?		
23. Before 1985 have you ever had injections of **growth hormone;** injections for **infertility treatment,** or tes injections for **hormone imbalance**?		
24. Have you ever had **malaria , hepatitis** or **jaundice**		
25. Have you lived in a malarial area for more than 3 months before you were 5 years old?		
26. Have you ever travelled or lived outside western Europe, USA or Canada?		
27. Have you ever had a fever while abroad, or shortly after your return to the UK?		

FOR ALL DONORS

You should NEVER give blood if:

- you, or your partner are HIV positive
- you carry the hepatitis B or C virus
- you are a man who has had sex with another man, even "safe sex" using a condom
- you have ever worked as a prostitute
- you have ever injected yourself, even once, with drugs (including body-building drugs)
- you think you need an HIV or hepatitis test

	Yes	No
COULD ANY OF THE ABOVE APPLY TO YOU?		

You should not give blood FOR A YEAR after sex with:

- a man who has had sex with another man (if you are a woman)
- a prostitute
- anyone who has injected themselves with drugs
- anyone with haemophilia or other related blood clotting disorder who has received clotting factor concentrates
- anyone, of any race, who has been sexually active in Africa* in the past year. (* Apart from Morocco, Algeria, Tunisia, Libya or Egypt).
- someone you think might be HIV or Hepatitis positive

	Yes	No
COULD ANY OF THE ABOVE APPLY TO YOU?		

Do you wish to speak in confidence to a doctor or nurse?	Yes	No