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PEH/ESS

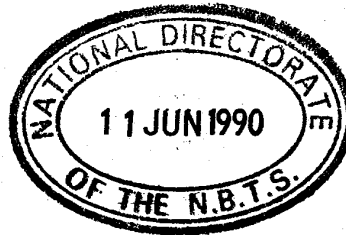
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Dear Harold

Post-transfusion hepatitis B (PTHB) reports; Summary for North London Blood Transfusion Centre 1986-1989

In view of our recent experience, Marcela asked me to review our PTH reports over the last four years with particular emphasis on the serological characteristics of donors implicated or possibly implicated in cases of PTHB.

Between 1986-1989 there were a total of 14 reports of hepatitis B to us which we felt were likely to be associated with blood transfusion. As you will see, we investigate 3-4 cases of possible/probable post-transfusion hepatitis B each year. Two of these (J10/87, J3/89) were felt to be due to transfusion abroad and no recall of NLBTC donors followed. In a further two cases (J2/88 and J5/88) there was no donor follow-up because the reports involved an incidental finding of HBsAg positivity in a multi-transfused recipient, without any indication of date of seroconversion (or indeed, proof of a previous HBsAg negative status).

In 8 of the remaining 10 cases, an attempt was made to contact all involved donors. The response rate was high, although not complete. In 3 cases, all resampled donors were negative for HBV markers (J6/87, J13/88, J2/89) and in another 3 one resampled donor was anti-HBc positive (J5/86, J4/87, J10/88) and withdrawn as "possibly implicated". One case (J8/87) was predicted by us, when a donor was detected HBsAg positive at the next donation, the previous donation was subsequently confirmed HBsAg negative. This donor was obviously in the early infectious stage of hepatitis B infection, but below the level of detection in HBsAg screening tests, at the time of the implicated donation. The final case (J5/89) has been fully documented.

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This leaves 2 cases (J7 and J10/86) where the numbers of donors involved were huge, and recall of all donors thought to be logistically impossible. Examination of records revealed a common donor, found to be anti-HBc positive on recall.

Thus, out of 14 documented cases in 1986-1989;

- 4 - not investigated for reasons given
- 5 - "implicated" donor anti-HBc positive, HBsAg negative
- 3 - no HBV markers identified in resampled donors and no donor implicated
- 1 - donor in early stage of HBV infection, but HBsAg negative
- 1 - donor had low level HBsAg.

This summary indicates that the checking of original HBsAg results on donors involved in PTHB enquiries is unlikely to be of help to BPL in deciding the fate of "held" products. Our latest report to BPL (J2/90) involving 183 donors and 120 plasma donations forwarded to BPL required 15 hours of Senior Scientific Officer time to check original HBsAg results. If the checking of previous HBsAg test results is now to be part of BPL's requirements, we shall obviously require additional resources!

With kind regards.

Yours sincerely

GRO-C

DR P E HEWITT
Deputy Director

cc Dr R S Tedder
Dr H Pickles

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