

TBL19

Mary Samadina

Common planning activity
with Prof Thomas
afternoon and late PM on

TO: Dr Rejman

FROM: Dr J S Metters DCMO
20 February 1995

CC: Mr Scofield

GRO-C

HEPATITIS C LOOK BACK

1. I was disappointed to see from Professor Zuckerman's letter of 16 February to Professor Thomas that Arie will be unable to attend the next meeting of the Working Group. This is most unfortunate as we had hoped to clear the various guidelines. However, I note that Professor Zuckerman has referred to Professor Thomas' draft as "excellent". Let us hope the same view is taken by the rest of the Working Group.
2. Can you assure me that Professor Thomas will be at the meeting!

Margie,

Could you please find
me a phone number for

Prof Thomas? *Flower-stee*

able to find one
in the yearbook -
maybe on file!

J S Metters
Room 509
Richmond House

IA.43

GRO-C

✓ Prof Thomas will attend

GRO-C

23/2.

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Maggie - please
cc: Dr Walter,
Dr Heyman
T. Kelly
D. Burroughs
R. Scofield

TBL 19

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O-1/2
DRAFT

Transfusion-Transmitted Hepatitis C - Guidelines for Counselling Patients

These guidelines are intended for use in counselling patients found to have hepatitis C as a result of a previous blood transfusion. Recipients of blood or blood components from donors now known to be carriers of the virus are being traced with a view to providing counselling, testing and specialist referral as appropriate.

Transfusion services in the UK began screening for antibodies to HCV on 1 September 1991. Patients transfused subsequent to that date have a negligible risk of having been infected by the transfusion. Not all of those transfused with potentially infectious blood prior to the commencement of testing will, however, be identified by the 'lookback' procedure; the donors of the transfused materials may not have returned since September 1991. Thus, even in cases where the 'lookback' has not implicated an individual patient, it may only be possible to provide full reassurance by offering to test the patient for antibodies to HCV.

Patients confirmed to be anti-HCV positive should be counselled on the implications of the test result, and referred for a specialist opinion. It should be borne in mind that the infection may have been contracted as a result of risk behaviours other than the incriminated transfusion, and since this, and the duration of infection, may have some bearing on the prognosis and on the outcome of treatment, the patient should be questioned about such risk behaviours.

Implications of a positive test - prognosis

Patients are described as anti-HCV positive when a screening test for the antibody is repeatedly positive and the result has been confirmed by a recombinant immunoblot assay (RIBA). Most such patients will also be positive for HCV RNA using the polymerase chain reaction (PCR). PCR positive patients usually have raised transaminases (especially ALT), though this may be intermittent and unimpressive. It has been shown that virtually all of these patients have some abnormality on liver biopsy, and around 20% will go on to cirrhosis with an attendant increased risk of hepatocellular carcinoma. PCR negative patients usually have normal liver function and appear to have a good prognosis.

Epidemiology - modes of transmission

The commonest route of transmission is by sharing needles or equipment during intravenous drug use. Transfusion of blood or fresh components (platelets, fresh frozen plasma or cryoprecipitate) prior to the introduction of routine screening on 1 September 1991, or of clotting factor concentrate prior to the use of virus inactivation procedures in 1984, also carried a risk of infection. Other parenteral routes include tattooing, and, theoretically, electrolysis, ear-piercing and acupuncture. Sexual transmission occurs, but the frequency is controversial - most studies indicate infection rates of under 10% in sexual partners. Vertical transmission (mother to

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baby) appears to be rare. The risk of nosocomial infection, eg following a needlestick injury (involving HCV infected blood), is around 10%, ie intermediate between HIV and hepatitis B.

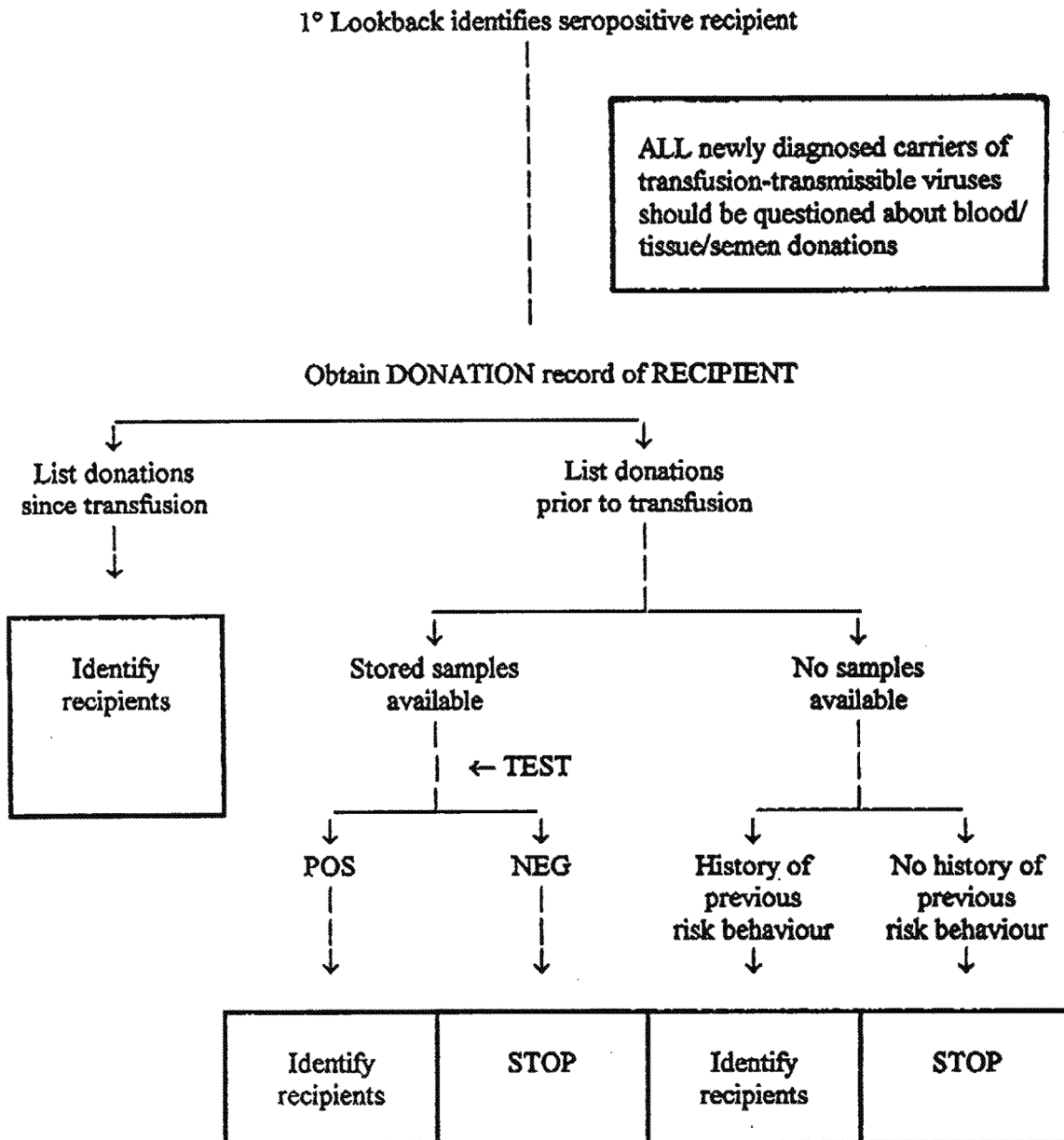
Avoiding infecting others

- 1 Anti-HCV positive individuals should not donate blood, tissue or semen, and should not carry an organ donor card.
- 2 Toothbrushes and razors should not be shared, and cuts or skin lesions should be covered with waterproof dressings.
- 3 When seeking medical or dental care, patients should be advised to inform those responsible for their care of their anti-HCV status.
- 4 Existing sexual partners should be offered testing. At present there is insufficient evidence to recommend changes to current sexual practices with a steady partner, though the possibility of infection must be discussed. Patients should be advised to practise safe sex with new partners.
- 5 There is no evidence to support advising against pregnancy, though the potential for transmission should be discussed.

Further assessment and follow-up

All anti-HCV positive patients should be referred to a specialist with an interest in the condition for further assessment. This will usually involve a period of observation, and, in most cases, a liver biopsy. Patients considered to be at risk of progressive liver disease may be offered treatment with interferon.

J Gillon

"SECONDARY" LOOKBACK PROCEDURE

"TERTIARY" LOOKBACK PROCEDURE