ADVISORY COMMITTEE ON THE MICROBIOLOGICAL SAFETY OF BLOOD AND TISSUES FOR TRANSPLANTATION
MINUTES OF MEETING: 30 JANUARY 2002
ROOM 102/124A, SKIPTON HOUSE

Chair: **Dr Pat Troop**
Members:
Dr Cant
Dr Dash
Dr Gorst
Dr McClelland
Professor McMaster
Dr Mortimer
Dr Perry
Dr Robinson
Dr Warren
Dr Wyatt
Professor Zuckerman

Observers:

Mr Stephen Lee	-	MDA
Dr John Stephenson	-	DH
Dr Joyce Lawrence	-	MCA
Dr Vicki King	-	DH
Dr Peter Doyle	-	DH
Dr Peter Bennett	-	DH
Mr André Hare	-	DH
Mr Armin Kirthi-Singha	-	DH
Dr Aileen Keel	-	SE
Dr Mike Simmons	-	NAW

Secretariat: Jill Taylor and Olivier Evans

ITEM 1: WELCOME AND APOLOGIES FOR ABSENCE

1. The Chairman welcomed Dr Philip Comer and Dr Mark Purcell from Det Norsk Veritas, Professor James Ironside, Professor Don Jeffries and Dr Geoff Ridgway from the CJD Incidents Panel and Dr Philippa Edwards from the CJD Incidents Panel Secretariat for **Item 4.** Dr Lorna Williamson from the National Blood Service also attended.

2. Apologies were received from Mr Forsythe, Dr Lorraine Doherty(Northern Ireland) and Dr Amal Rushdy DH.

ITEM 2: MINUTES OF THE MEETING OF 22 OCTOBER

3. The minutes of the last meeting had been circulated to members. The Chair asked for any comments.

- It was noted that at Item 4, Para 8 line 4 "…. HIV infectious donation every 3 years…" **should read** "every 2 years" and at Para 9, line 3 "….from one infection per annum to three to six as well as the risk from other sexually transmitted TTIs…." **should read** " from one infection every two years to six for (a) above and 12 for (b) above as well as the risk from other sexually transmitted TTIs.."

- Item 6, Para 22 line 8 "Ann Nicholl" **should read** "Angus Nichol" and that at Item 7, Para 32 line 3 " …was stricter…" **should read** "…less strict.."

ITEM 3: MATTERS ARISING

(i) HTLV Testing

4. The NBS had developed a strategy for HTLV screening using 48 mini-pools testing but had only identified one test kit produced by one manufacturer. This could cause problems if a fault were found with the kit. NBS could start testing when the technique was validated in 2002. Once testing was started a "look back" exercise would be required. The transfusion transmission rate is 30% from contaminated cellular blood components.

5. The Chair asked about the implications for those people found in any lookback exercise and was informed that they would need to be referred to a specialist centre for counselling and follow up.

Action: Chair to write to NBS to confirm HTLV testing should start.

(ii) Blood Safety Leaflet

6. Members were advised that the Expert Advisory Group on AIDS (EAGA) had considered papers presented to the October MSBT meeting:

- Dr Kate Soldan's paper and conclusions – **MSBT 25/1**
- Professor Ann Johnson's paper - **MSBT 25/1B**
- Paper from EOR – **MSBT 25/1A**

7. Those EAGA members who represented voluntary sector/community groups, the Terence Higgins Trust, Mainliners and African Community groups, were disappointed that they had not been given the opportunity to comment on the papers and had not been invited to the October meeting of MSBT when discussion took place. They strongly requested more involvement at the next review. EAGA members also recommended a representative from the Patients Association should be included.

8. One of the most sensitive issues in the paper was compliance, currently there is 95% acceptance in the gay community and any adverse publicity about self deferral might affect this. The Chair said that MSBT will need to look at bringing all the community groups into the discussions at the next review. It was agreed that the revised leaflet would contain the following changes from:

" You should not give blood for a year after sex with anyone, of any race, who has been sexually active in Africa in the past year. This is because the main route of HIV infection there is heterosexual sex"; to

"You must not give blood for at least a year after sex (even if you used a condom or other protective) with a partner who has, or you think may have been, sexually active in parts of the world where HIV/AIDS is very common. This includes most countries in Africa"

9. The Chair said that EAGA members needed to be specifically consulted on this change to ensure they were content. The Chair said that providing there was full agreement by EAGA, NBS could be advised to go ahead and issue the leaflet. The next EAGA meeting was 19 March 2002 but members would be consulted about the leaflet by correspondence.

Action:

i). Dr King to ensure that EAGA members are content with the revised wording of the leaflet at the next meeting.

ii). MSBT Secretariat to ensure voluntary/community group members of EAGA are consulted at the next review of the Blood Safety leaflet.

10. At the last meeting an issue was raised about the surveillance of people born after 1996 in terms of blood transfusion as a risk factor for vCJD. It had been agreed by Professor Angus Nichol, Director of PHLS CDSC that the British Paediatric Surveillance Unit (BPSU) study on Progressive Intellectual and Neurological Deterioration (PIND) in children was undertaking this surveillance.

ITEM 4: PRESENTATION BY DET NORSK VERITAS (DNV) "RISK ASSESSMENT OF vCJD INFECTIVITY IN BLOOD AND BLOOD PRODUCTS" – MSBT 26/1

11. Members were informed that The Det Norsk Veritas (DNV) risk assessment would be used to evaluate the potential risk to individual recipients of products derived from blood from donors who went on to develop vCJD. The risks should be put in context with the risks of transmission through surgical instruments and the background risk from historical consumption of food products derived from cattle with BSE. The paper would also be submitted to the Committee on Safety of Medicines (CSM), the Spongiform Encephalopathy Advisory Committee (SEAC) and the CJD Incidents Panel. MSBT members were invited to respond to the questions in Annex 2 of the covering paper to MSBT 26/1.

12. DNV gave a presentation on MSBT 26/1 to Members. The DNV conclusions were that:

- It is not possible to make a reliable assessment of the risk from any vCJD infectivity that may be present in the blood of a person incubating the disease

  - we do not know how many people may be infected
  - we do not know if blood is infective

There is no evidence to confirm that the blood from a person with CJD or vCJD is infective

- Evidence from animal models suggests that the blood from an animal infected with a TSE may be infective, albeit at a low level.

- If there is infectivity present in blood at the level suggested by animal models (Brown and Rohwer) then the infectivity present in a full unit of red cells, platelets or plasma from an infected donation may be sufficient to cause infection.

    - This conclusion seems to be valid across a wide range of assumptions

- The infectivity levels in certain plasma derivatives, if made from a pool containing infected donations, may also be able to cause infection.

    - This conclusion is highly uncertain, and varies significantly with the assumptions made.

13. The Chair asked members if they agreed that all relevant available information had been included and if they considered that the information was correct.

14. Members discussed the data in the paper and commented that Appendix 3 referred to 5 year old Serious Hazards Of Transfusion (SHOT) data, when other data was now available. DNV agreed and said that they may need to do a review or to remove sections of the report that had not been updated and were not required for the work of the CJD Incidents Panel.

15. Members of the CJD Incident Panel expressed disappointment with the results, it had been hoped that the data would be up to date so that a decision could be made by the Panel. If other data was required it should be seen urgently. It was noted that although it was not thought that there was any additional key data, the FDA may have had access to information that was not generally available. Clearance studies using brain material should not be ignored.

16. The NBS said that there were no infectivity studies since the original report, the assumptions were not up to date to take account of actual leucocyte numbers and the effect of leucodepletion. An updated report would be used for forward planning for the NBS and it would be worth getting the Appendices updated. The NBS would need MSBT advice on whether to exclude transfusion recipients. The Chair suggested that this work should continue separately as the DNV Report needed to go forward to the CJD Incidents Panel, which would also be considering incidents occurring prior to the introduction of leucodepletion.

17. A number of risk assessments had been carried out in the US, France and Germany. It was suggested that a review be made of other groups of experts who have already looked at the issues involved. The Chair said that a precautionary approach had been taken on the policy in the UK.

18. The Chair said that there were still questions about the research data contained in the report and that a small expert group could look at the assumptions and also comparisons with other risk assessments.

19. The CJD Surveillance Unit (CJDSU) were looking at infectivity in a wide range of tissue including bone marrow, the WHO Panel on Diagnostic Tissue had proposed establishing a stock of contributed spleen material for use as potential spikes for measuring the effect of processing on infectivity in blood products.

20. The Chair said that whilst there were positive views about the risk assessment more work was needed. The risk assessment needed to go to CSM and in April to SEAC. The CJDSU had found that there was no evidence that repetitive dosing increased infectivity. The Chair asked that CJDSU forward any material that may be helpful.

21. It was noted that many of the less up-to-date sections concerned population risks rather than individual incidents and it might be simpler to omit these, given the CJD Incident Panel's requirements. There was a need to distinguish clearly between historical risks (from donations processed years ago) and prospective risks given the extra precautions now in place.

22. Economic and Operational Research Division (EOR) were modelling blood transmissions for MSBT to predict what proportion of observed cases could be through blood, consistent with DNV's suggested level of infectivity. Of 113 cases of vCJD, 5 had received transfused blood. A paper analysing the findings was nearly ready but could be extended to consider the receipt of vCJD implicated blood products by known individuals.

23. Members were asked to consider question 8 of Annex 2 and if the dose rates were incorrect to inform the Secretariat.

24. There was concern about one of the main conclusions in the paper i.e. that because there is infectivity in blood in animal models, then the infectivity is present in a full unit of red cells, platelets, plasma etc. It was queried whether there would be concerns if blood users were asked to give consent to receipt of a blood product that could not be guaranteed free from CJD infectivity. It was felt that many patients needed the blood products because of serious health problems and may think of the immediate issues and not the future.

Action:

i) Establish a small expert group (Dr Perry MSBT, Dr.Foster, Lorna Williamson NBS, Dr. Harrison BPL) to consider Q6 of Annex 2 of MSBT 26/1 and do further work on clearance factors during processing. - Dr Edwards and MSBT Secretariat to set up expert group.

ii) MSBT members to contact Dr Edwards if there is any incorrect information regarding the maximum individual/annual dose rates for different products (Q.8 of Annex 2 – MSBT 26/1). - MSBT members to respond if necessary.

iii) Proposals for handling repeated doses with potentially contaminated products (Q7 of Annex 2). - Professor Ironside to provide MSBT data on whether infectivity requires one critical dose level or whether it can be cumulative.

iv) EOR Risk assessment paper – further progress to be made on this - Mr Hare/Dr Bennett

ITEM 5: EXCLUSION OF TRANSFUSION RECIPIENTS

25. In June 2001 EOR had provided MSBT with a paper on the risk benefits of those who had received blood in the past. At the last MSBT meeting EOR reported that they could provide a model on the risk benefits but would have to rely on the DNV review and NBS to input on data on blood usage and age groups.

26. Members were informed that there was nothing in the DNV paper that would change substantially EOR's conclusions in the paper produced for the June 2001 meeting. Neverthless EOR would produce a revised paper with more up to date inputs on product usage and with more extensive sensitivity analysis.

27. The Chair asked NBS about the potential impact of a 10% reduction in the blood supply on hospitals as this needed to be considered in the EOR paper and NBS agreed to provide a paper for the next meeting for final discussion.

Action: Dr Robinson to provide paper on the potential impact on 10% reduction of blood supplies on hospitals.

ITEM 6: FRESH FROZEN PLASMA (FFP)

28. The Chair told members that issues relating to FFP are currently in the spending review process. However, the top priority was securing a supply of plasma. Before putting these issues to Ministers they must be prioritised and this is being done. The funding for providing FFP to neonates is being worked through already but not for other categories of recipients.

29. There may be a need to consider age differentials, pending the amount of FFP imported from the US. It may mean that certain categories would not be able to receive imported FFP. NBS pointed out that the time being taken to sort out other years meant a decision had not been made 2002/03. The Chair told members a decision would be made shortly on neonates but as Ministers would not want to look at the issues piecemeal and funding could not be committed unless agreed by Treasury. The Scottish Executive said that in Scotland Ministers had agreed importing FFP but there was no funding available. The Chair said that the issues on neonates would be raised with Ministers for 2002.

ITEM 7: REDUCING THE RISK OF TRANSFUSION - MSBT 26/2

i. Skin piercing regulation

30. At the last meeting concerns were raised about the risk of blood-borne viruses from skin piercing and the regulation of this practice.

31. Members were told that in London local authorities had specific powers to regulate ear piercing, body piercing, tattooing, acupuncture, electrolysis and micro pigmentation businesses by licensing and inspection under the London Local Authorities Act 1991 (although some local authorities in London still used the Greater London Council (General Powers Act 1981). Local Authorities may impose licence conditions relating to matters such as cleanliness, hygiene and safety. It is a criminal offence for a business to trade without being licensed or to breach licence conditions.

32. Outside London local authorities operated under separated legislation giving them specific powers to regulate ear piercing, tattooing, acupuncture and electrolysis businesses (Local Government (Miscellaneous Powers act 1982)). Local authorities have powers to regulate those businesses by requiring registration and the observance of byelaws about hygiene and cleanliness, and inspection. It is an offence for a business, offering ear piercing, tattooing, acupuncture or electrolysis to trade without being registered or to breach byelaws. Body piercing and micropigmentation businesses are not covered by the current legislation. Ministers have decided to introduce primary legislation to give local authorities powers to regulate those businesses when parliamentary time allows. Local authorities have general enforcement powers over skin piercing businesses under health and safety at work legislation, which allows them ultimately to prosecute cosmetic body piercing businesses if there was a risk to customers' health and safety.

33. Scotland does not have any specific legislation regulating skin piercing businesses (except locally in Edinburgh). The Health and Safety at Work Act 1974 applies as in England. Following a consultation exercise in 2001 on the regulation of skin piercing the Scottish Executive hopes to make an announcement about Ministers intentions in 2002. The legislation in Northern Ireland is similar to that applying outside London. The minimum age for consent for tattooing is 18 years but there is no statutory age of consent for ear or body piercing. Minors are able to give valid consent if they are capable of understanding the nature of the act. There is no body of epidemiological evidence that infection occurs commonly from this route.

34. Clarification of paragraph 8 of the paper "If a minor were competent to give consent, this would override the wishes of the parent" was requested. In reply it was explained that the courts had held that a parent's right to decide on behalf of a child yielded to a child's competence to make the decision. To be competent the child would need to be capable of understanding the nature of the act to be carried out. This would depend in each case on the relative maturity of the child, as well as on his/or her age.

35. It was noted that NBS had similar difficulties with age of consent for donors and could be ruled by a court to be committing assault if a donor were found to be under the age of consent and not to demonstrate Gillick competence.

i. Tissue and Organs

36. Members were informed that if recipients who receive transfused blood from vCJD donors were excluded from donating blood then donors of tissue and organs should also be considered.

Action: To consider the implications of excluding tissue/organ donation – EOR

ii. Appointment of analysts

37. At the last meeting in October NBS reported that it had agreed to fund 2 posts within DH to work on blood and tissue safety. EOR informed members that one analyst had been appointed and the second would be appointed next month.

ITEM 8: ANTI-MALARIAL TESTING

38. The NBS informed members that routine malaria antibody testing (MAT) was introduced throughout the National Blood Service in April 1998. It was discontinued in July 1999 because the single supplier of a suitable validated test kit could no longer provide kits, which met the standards required by the NBS. Since then, NBS scientists have been working with test kit manufacturers to identify suitable alternatives.

39. Since the Autumn 2001, a pilot study has been undertaken involving Blood Collection Teams based at North London. If it is at least 6 months since a donor's return to the UK from a malarious area, a donation can be collected providing MAT is carried out on that donation.

40. NBS reported that a test has been implemented in London South East Zone and will be rolled out nationwide.

ITEM 9: BETTER BLOOD TRANSFUSION

41. The UK CMOs "Better Blood Transfusion" Conference on 29 October 2001 had been a very successful day, attended by 130 delegates with speakers representing the National Blood Service, the National Audit Office, Serious Hazards of Transfusion Group (SHOT), a patient representative and specialists in blood use.

42. Following the conference and taking into account the views put forward in workshops the Department was developing new guidance for health authorities and NHS Trusts which would be issued in the Spring. The new guidance would include:

- managing blood use at Trust level by establishing a hospital transfusion committee and a hospital transfusion team.
- providing regular training in safe effective practice.
- providing patient information about blood transfusion and alternatives.

- agreed protocols for safe and effective practice based on national guidelines.

- pre-operative assessments and use of patient's own blood – exploring use of autologous transfusion and alternatives to transfusion of donor blood.

- safety – ensure all patients (including outpatients) have patient identification.

ITEM 10: UPDATE ON EUROPEAN BLOOD DIRECTIVE – MSBT 26/3

43. Members were informed that the Directive on blood and blood components had successfully passed the Health Council on 15 November 2001 and was due to go to the European Parliament for second reading in February/March. The text had been discussed on 18 in Jurist-Linguists and an official version of the Directive would be published shortly on the Commission website. The Department would carry out a further consultation exercise based on the new text.

44. The UK had removed obstacles to the importation of paid donor plasma for fractionated blood products from the US as a vCJD risk reduction measure. Members pointed out that the UK would be very vulnerable if the EC changed its mind and we were unable to use paid donors. It was agreed that a further update would be provided for the next meeting,

Action: Update to be provided for meeting in June - Secretariat

ITEM 11: STORAGE OF SERUM SAMPLES

45. At the MSBT meeting in June 2001 an item was raised following a letter from Dr Westmoreland (PHLS Wales) on the storage of serum samples. Since that meeting the Council of Europe Guide to the Safety and Quality Assurance for Organs, Tissues and Cells had been completed in November and helpfully recommended that samples should be "archived according to local regulations". Members were informed that, the issue had now been included in a draft EU Directive on tissue banking. The current draft was confusing as in one place it suggested that all records, including samples, should be kept for a minimum of 10 years after all relevant tissues have been transplanted. In another annex it suggested all records should be kept for 30 years. A meeting would be held in Malaga on 6 February to consider the first draft.

46. Members were told that it would be the first time that serum samples had been kept for 30 years. The NBS informed members that a decision had just been made not to do a lookback before 1980 as there are no traceable hospital records. If the Directive is accepted then records might have to be kept. Members noted that brain samples that were 20 years old could be used to detect prions.

47. The Chair said that if this moves quickly, views would be needed on what the implications might be. It was suggested that a small group be set up to look at this issue and include stem cells.

48. There was a suggestion that a minimum of 10 years should be used and review again once the group had reported. The Chair told members that this was a fundamental decision to make and asked for a short paper for the next meeting.

Action:

i.) Set up an expert group to look at storage and record keeping of tissues (to include stem cells) – Dr Doyle

ii) Prepare a paper, updating European issues for the next MSBT meeting in June - Dr Doyle and Dr Mortimer

ITEM 12: ANY OTHER BUSINESS

49. No items for discussion.

ITEM 13: DATE OF NEXT MEETING

50. The next meeting would be held on Tuesday 25 June 2002.