Health Protection Agency

CJD Section
Centre for Infections
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To: UK Haemophilia Centre Doctors

Dear Colleague,

Post mortem finding of asymptomatic variant Creutzfeldt-Jakob Disease abnormal prion protein in a person with haemophilia

A person with haemophilia has been found to have evidence of infection with the agent (abnormal prion protein) that causes variant Creutzfeldt-Jakob Disease (vCJD) only in his spleen at post mortem. Tissue from the post mortem was examined as part of a study jointly co-ordinated by the UK Haemophilia Centre Doctors Organisation and the National CJD Surveillance Unit.

This haemophilia patient had been treated in the 1990s with several batches of UK sourced clotting factors, including one batch of factor VIII that was manufactured using plasma from a donor who went on to develop vCJD. The plasma donor developed symptoms of vCJD 6 months after donating the plasma in 1996. The haemophilia patient was in his 70's when he died of a condition unrelated to vCJD, 11 years and one month after receiving the batch of implicated Factor VIII. He had no signs or symptoms of vCJD or other neurological disease when alive.

A final view as to how vCJD abnormal prion protein was transmitted to this haemophilia patient has yet to be reached because investigations are continuing to be sure of the source.

This is the first time that vCJD abnormal prion protein has been found in a patient with haemophilia, or any patient treated with plasma products.

This case does not change the public health vCJD 'at risk' status of any of your patients with bleeding disorders.

Please take these actions:

1. **Send the enclosed letter to <u>all</u> your patients with bleeding disorders (including those not at risk of vCJD).**

   Please do this as quickly as possible. It is planned that the letter to patients will be published on the HPA, the UKHCDO, and UK Haemophilia Society websites on Thursday February 19th 2009.

2. **Make arrangements for appointments with any concerned patients.**

   Some of your patients may wish to discuss this new information with you. In 2004 all patients at risk of vCJD should have been offered the option of finding out whether they had been treated with clotting factor batches that had been manufactured using plasma from donors who later developed vCJD. Please check their preference recorded at that time. Some patients may now wish for more information, and may wish to know about the batches of plasma product they received. Please try to ensure that patients have an opportunity to discuss this with you.

Information leaflets for patients and for healthcare staff are enclosed for prompt distribution. These are also available on the HPA website http://www.hpa.org.uk/CJD

Further information

If you would like further information about this letter, please contact:

- Professor Frank Hill (Chairman of UKHCDO Working Party on Transfusion Transmitted Infections) on GRO-C
- Dr Charles Hay Chairman of UKHCDO) on GRO-C
- The CJD Section at the Health Protection Agency's Centre for Infections by e-mail to cjd@hpa.org.uk or by phone on 020 8327 6074
- (Wales only) Dr Roland Salmon (Consultant Epidemiologist, National Public Health Service for Wales) on GRO-C

Yours sincerely

GRO-C

Dr Charles Hay
Chairman
UK Haemophilia Centre Doctors' Organisation

GRO-C

Dr Nicky Connor
Consultant Epidemiologist
Health Protection Agency (Colindale)

Enclosed documents

1. Letter for patients.
2. Four information leaflets:
    - Information for people who have an increased risk of CJD.
    - Who has an increased risk of CJD?
    - Patients at increased risk of Creutzfeldt-Jakob Disease: Actions for healthcare staff.
    - Patients at increased risk of Creutzfeldt-Jakob Disease. Background information.

Additional Information

Other information that patients may wish to know:

Your patients may want to know whether they have received clotting factors manufactured using plasma from the same donor who may have been the source of the vCJD abnormal prion protein in the person with haemophilia. Plasma from this donor was used to manufacture four batches of BPL clotting factors (Table 1).

Table 1: Specific batches of BPL blood products that included plasma from the vCJD donor linked to the infected person with haemophilia

Product	Batch number	Date of plasma donation
Factor VIII 8Y[1]	FHB4547	02/05/96
Factor VIII Replenate[2]	FHE4548	02/05/96
Factor VIII 8Y	FHC4237	11/01/93
Factor IX 9A	FJA4239B	11/01/93

1. The haemophilia patient with vCJD abnormal prion protein was treated with this batch.
2. This batch was made from the same plasma pool as FHB4547

The new finding does not necessarily mean that patients treated with these four batches have a greater risk than patients treated with other implicated batches, as a further 23 implicated batches were also assessed to be high risk by the CJD Incidents Panel.

Infection control precautions and other safety measures:

All patients with bleeding disorders[1] who have been treated with UK-sourced pooled factor concentrates or antithrombin[2] between 1980 and 2001[3] are classified as at risk of vCJD for

[1] Defined here as congenital and acquired haemophilia (Haemophilia A and Haemophilia B), Von Willebrand Disease, other congenital bleeding disorders and congenital antithrombin III deficiency.
[2] ie. clotting factors and antithrombin made from pooled plasma. These include factor VIII, factor IX, factor VII, factor XI, factor XIII and prothrombin complex concentrates as well as antithrombin.

public health purposes. Special infection control precautions and other safety measures apply to these patients – see below. This letter does not change the previous advice. There is no need at present for any additional infection control actions.

Once the investigations concerning the new finding are complete, the CJD Incidents Panel (CJDIP)[4] will consider the implications for the infection control management of plasma product recipients notified as at risk of vCJD for public health purposes. Any changes to existing infection control precautions will be communicated in due course, but it may be judged that no changes are required.

Background information on the 2004 notification:

In 2004 the HPA, the UKHCDO and colleagues notified patients who had received plasma products manufactured using plasma from donors who had subsequently developed vCJD. That notification dealt with plasma donations which had been used to manufacture factor VIII, factor IX, antithrombin, intravenous immunoglobulin G, albumin, intramuscular human normal immunoglobulin and anti-D.

Patients treated with these plasma products were to be managed according to an assessment of potential vCJD infectivity carried out by the Health Protection Agency with the CJDIP.

The UK Haemophilia Doctors and patient representatives, the CJDIP and UK Health Departments agreed that it was likely that many patients with bleeding disorders would have had a sufficient exposure to these implicated plasma products to put them 'at risk' of vCJD for public health purposes. It was also thought likely that further batches of UK-sourced plasma products would be implicated in the future as more cases of vCJD arose.

Therefore all patients with bleeding disorders who were treated with UK-sourced pooled factor concentrates or antithrombin between 1980 and 2001 have been designated as 'at risk of vCJD for public health purposes' and special precautions should be taken following national guidance. This risk is in addition to the general risk of vCJD that many people in Britain have through eating beef or beef products.

Information given to patients in 2004:

All patients with bleeding disorders were to be told if they had received UK-sourced pooled factor concentrate or antithrombin between 1980 and 2001. Patients who had were to be:

a) informed that they had an additional risk of vCJD because they could have been treated with plasma made from donations from individuals who later developed vCJD.

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[3] The start date of 1980 is when BSE is thought to have entered the human food chain. The end date of 2001 is the last possible expiry date of any product manufactured by the UK fractionators that was sourced from UK donors until 1998.

[4] The CJDIP is an expert committee set up on behalf of the UK Chief Medical Officers to advise on the management of 'incidents' of potential transmission of CJD between patients.

b) given the opportunity to find out whether they had been treated with an implicated batch. They were told that if any more implicated batches were reported, then their exposure assessment might change.

c) informed that they were 'at risk of vCJD for public health purposes', and that their 'at risk' status would be recorded in their hospital medical records and primary care notes. Their exposure to implicated batches, and whether they had asked to know if they have received implicated batches, was recorded in their hospital medical records on a Patient vCJD Exposure Assessment Form. Patients who had **NOT** received UK-sourced pooled factor concentrate or antithrombin between 1980 and 2001 had this fact clearly recorded on this form.

d) informed that special precautions needed to be taken to reduce the chance of any further spread of vCJD, and were given the following advice:

   - They should not donate blood, organs or tissues (many patients who have received plasma products may already be excluded from donation because of their underlying condition)
   - They should inform their doctors and other healthcare professionals of their 'at-risk' status, so that special infection control precautions could be taken before surgery and other invasive procedures should they require future medical care. They were advised to inform their families, in case they needed emergency surgery in the future.

e) reassured that their clinical care should not be compromised in any way.