→ FGHH

Mann Pat (RQ3) BCH

From: Christopher Ludlam [Christopher.Ludlam@ GRO-C
Sent: 17 December 2003 15:58
To: Mann Pat (RQ3) BCH
Subject: Re: Public Health Link: BLOOD TRANSFUSION INCIDENT INVOLVING VCJD [URGENT (cascade within 24 hours)]

Thanks
I had heard earlier today from SNBTS. I will pass statement on to all Scot Haem Directors. We shall attempt to work with SNBTS over any statement for the media.
I have discussed with Gordon Lowe and we shall probably;y send a letter round all haemophiliacs is Scotland in the next few days about it.
What else would you like me to do at present?
Christopher

Christopher A. Ludlam
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----- Original Message -----
From: "Mann Pat (RQ3) BCH" <PAT.MANN@ GRO-C
To: "'Charlie Hay'" <CHAY@ GRO-C "'Christopher Ludlam'" <Christopher.Ludlam@ GRO-C
Sent: Wednesday, December 17, 2003 3:06 PM
Subject: FW: Public Health Link: BLOOD TRANSFUSION INCIDENT INVOLVING VCJD [URGENT (cascade within 24 hours)]

> Professor Hill has asked me to forward a copy of this on to you both.
>
> Regards
>
> Pat Mann
> (Secretary tof Professor F.G.H. Hill)
>
> Dept. of Clinical & Laboratory Haematology
> Birmingham Children's Hospital NHS Trust
> Steelhouse Lane
> Birmingham B4 6NH.
>
> -----Original Message-----
> From: Messages_Urgent_CMO@ GRO-C
> [mailto:Messages_Urgent_CMO@ GRO-C
> Sent: 17 December 2003 14:23
> To: Messages_Urgent_CMO@ GRO-C
> Subject: Public Health Link: BLOOD TRANSFUSION INCIDENT INVOLVING VCJD
> [URGENT (cascade within 24 hours)]
> Importance: High
>
>
> Cascade Codes: #GP#
>
>
> To: NHS Trusts - Medical Directors (England)
> Primary Care Trusts - Directors of Public Health
> Primary Care Trusts - Medical Directors
> Public Health Link

>
> Cc: Chairman - Professional Executive Committee of PCT
> Consultants in Communicable Disease
> Regional Directors of Public Health
> Strategic Health Authorities (England) - Directors of Public
> Health
> Territorial CMOs
>
> From: Sir Liam Donaldson - Chief Medical Officer - Department of
> Health
> Date: 17 December 2003
> Reference: CEM/CMO/2003/21
>
> Category: URGENT (cascade within 24 hours)
>
> Title: BLOOD TRANSFUSION INCIDENT INVOLVING VCJD
>
> This broadcast will be available online shortly at:
>
http://www.info.doh.gov.uk/doh/embroadcast.nsf/vwDiscussionAll/0301ECC6DF485
> EF880256DFF004DA063
> To view the main website please go to:
> http://www.info.doh.gov.uk/doh/embroadcast.nsf
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>
> To: Directors of Public Health of PCTs to forward to:
>
> - All GENERAL PRACTITIONERS - please ensure this message is seen by all
> practice nurses and non-principals working in your practice and retain a
> copy in your `locum information pack'.
> - Deputising services
> - Project manager/Nurse lead in Walk in Centres
> - PCT lead nurses
> - Leads at nurse-led PMS Pilots
>
> To: Medical Directors of NHS Trusts to forward to:
> - Consultant Haematologists
> - Consultant Neurologists
> - Nurse Executive Directors of NHS Trusts
> - Staff involved in blood transfusions
>
> Cc:
> - Regional Directors of Public Health
> - Directors of Public Health of Strategic Health Authorities
> - UK CMOs
> - Chairmen of Professional Executive Committee
>
> Dear Health Professional
>
> Blood transfusion incident involving vCJD
>
> Below is a statement announced by the Secretary of State for Health in
> Parliament today. I am sending you this for your information as you may
get
> patients coming to you with questions relating to this. Anyone who is
> concerned can ring NHS Direct on: 0845 4647. NHS Direct are being advised
> on this issue by the Health Protection Agency.
>
> Statement
> "With permission Mr Speaker I wish to make a statement about a blood
> transfusion incident involving variant Creutzfeldt-Jakob Disease (vCJD).
>
> It might assist the House if I begin by setting out the basic facts before
> coming on to discuss the implications.
>
> In March 1996, a blood donor, who was at the time free of the signs of

> vCJD, donated blood to the National Blood Service. Shortly after this the
> donated blood was transfused into a patient who underwent surgery for a
> serious illness.
>
> In continuing my description of these events to the House, I will from now
> on refer to these individuals as the 'donor' and the 'recipient' of the
> blood.
>
> The donor showed no signs of vCJD at the time blood was given, but
> developed the disease three years later ? i.e. in 1999 ? and died from it.
> The recipient of the blood died in the autumn of 2003. Initial
post-mortem
> examination of the recipient of the blood showed changes in the brain
> indicative of CJD. Further examinations and tests of this patient's brain
> confirmed the diagnosis of variant CJD. The link between the donor and
the
> recipient was first reported to officials in my Department on 9 December
> 2003 at which time the diagnosis of vCJD in the recipient was still being
> confirmed.
>
> I was first alerted to the developments on Friday 12 December and was
> briefed by the Chief Medical Officer on Monday and Tuesday this week.
Today
> I am bringing this information to the House at the earliest opportunity.
I
> have given the minimal clinical details of the recipient because the
family
> has indicated that they wish to have their privacy respected.
>
> In the light of the facts which I have outlined, it is therefore possible
> that the disease was transmitted from donor to recipient by blood
> transfusion, in circumstances where the blood of the donor was infectious,
> three years before the donor developed vCJD, and where the recipient
> developed vCJD after a six and a half year incubation period. This is a
> possibility not a proven causal connection. However, it is also possible
> that both individuals separately acquired vCJD by eating BSE (Bovine
> Spongiform Encephalopathy) infected meat or meat products.
>
> This is a single incident, so it is impossible to be sure which was the
> route of infection. However, the possibility of this being
> transfusion-related cannot be discounted. That is the conclusion of the
> Chief Medical Officer and experts.
>
> It is because this is the first report from anywhere in the world of the
> possible transmission of vCJD from person to person via blood that I
> thought it right to come to the despatch box to inform the House on a
> precautionary basis.
>
> This incident was discovered by good surveillance. In 1997, the
Department
> of Health funded a research study, the Transfusion Medicine Epidemiology
> Review (TMER) study to examine links between all vCJD cases and any form
of
> blood transfusion. It is through this research study that the association
> between these two patients was identified. I should also point out that
> this emphasises the importance of post-mortem examination. Without it we
> would never have known about these matters. I would like to thank our NHS
> pathologists for their expertise and constant vigilance.
>
> I can inform the House there is as yet no blood test for vCJD (or for that
> matter BSE) let alone one that could detect the disease years before
> symptoms develop. So, there is no way yet of screening blood donations
for
> the presence of the CJD group of diseases.
>
> Fortunately, however, a range of precautionary measures have been put in
> place by the Government since 1997, even though there was at that time no
> evidence of the risk of person-to-person transmission of the disease via
> blood. For the reassurance of the House, I will briefly set out the
action
> that has been taken to date and the further action that we now propose.

>
> Firstly, since 1997 all cases of vCJD that are reported to the National CJD
> Surveillance Unit and diagnosed as having 'probable' vCJD, result in a
> search of the National Blood Service blood donor records. If the patient
> has given blood, subsequently any stocks of that blood are immediately
> destroyed.
>
> Secondly, on 17 July 1998 acting on expert advice, the Government announced
> a £70 million programme to remove most of the white cells from blood
> destined for transfusion. White cells were considered by experts at the
> time to be a potential source of infection. This process of so-called
> leuco-depletion was then a highly precautionary measure to reduce what was
> then a hypothetical source of infectivity. The process of leuco-depletion
> was implemented by the National Blood Service over time and completed by
> October 1999.
>
> Thirdly, on 12 November 1998, again acting on expert committee advice, the
> Government announced a £30 million programme to phase out the use of United
> Kingdom-sourced plasma in the manufacture of blood products. This was at
> the time (in the absence of any defined risk) another highly precautionary
> measure. From the end of 1999 all blood products have been made using
> plasma sourced from the United States of America. To ensure continuity of
> supply the Department of Health purchased on 17 December 2002 the largest
> remaining independent US plasma collector, Life Resources Incorporated.
>
> Fourthly, the National Blood Service has informed us that 15 people
> received donations of blood from donors who subsequently developed vCJD.
> Of the 15 individuals, we have been informed that five received blood after
> leuco-depletion had been implemented, the remainder before. The earliest
> such transfusion was in 1993 and the latest in 2001. Working with the
> National Blood Service, the Health Protection Agency is in the process of
> contacting these individuals. All will be told about the circumstances of
> their case and have the opportunity to discuss the risks with an expert
> counsellor.
>
> Many more patients of course, including haemophiliacs, will have received
> plasma products before plasma was sourced from the USA. They will have
> received products derived from large pools of plasma donated from many
> thousands of people and thus heavily diluted. The UK-wide CJD Incidents
> Panel considers the risks for this group to be even lower than for those
> who received whole blood. It is very difficult to trace all individual
> recipients of products made from these plasma pools. However, the CJD
> Incidents Panel will be advising on a case-by-case basis which recipients
> will need to be contacted as the necessary information becomes available.
> This group of patients will also have the opportunity for a discussion with
> an expert on an individual basis. Any person with concerns may ring NHS
> Direct on 0845 4647.
>
> Fifthly, before these events, expert groups were already deliberating on
> whether further measures were required in relation to vCJD and blood. In
> October of 2003 our expert committee on the Microbiological Safety of Blood
> and Tissues for Transplantation advised, on the basis of a risk assessment,
> that further action such as stopping people who have received a blood
> transfusion from giving blood was not necessary.
>
> However, in the light of today's statement, we have asked this Committee to
> look comprehensively at whether further precautionary measures could be
> taken which would not adversely impact on the safety or availability of
> blood.
>
> Sixthly, it is apparent that much more blood and blood products are used
> clinically, than need to be. There have been many past attempts to reduce
> the use of blood to situations where it is absolutely needed medically,

but
> these have only been partially successful. I will be asking the National
> Blood Service to have urgent discussions with the medical Royal Colleges
> and NHS hospitals to address this area of clinical practice. More
> appropriate blood usage will reduce all the risks associated with blood
and
> will make more effective use of our precious blood supplies.
>
> A finding of this kind, albeit one whose full medical significance is
still
> far from clear, inevitably will give rise to concern. It is therefore
> important to take account of the wider context in two respects.
>
> Firstly, since the events in 1996, approximately 24 million units of blood
> or blood components have been given to patients in the United Kingdom.
> Blood transfusion can be a life saving treatment but no medical treatment
> is free of all risks. Indeed it is an unfortunate fact that already each
> year approximately 12 die as a complication of blood transfusion. Many
> people receiving blood transfusion are already very ill, some in life and
> death situations. A wide range of measures are routinely used to reduce
> the risks of transfusion by screening for HIV/AIDS, hepatitis B and C and
> other infections. For specific high risk patients even more detailed
> screening takes place.
> These wider measures should be seen in the context of the precautionary
> action already taken on vCJD, and a recognition that so far we have only
> one single report of a possible link between a single donor and a single
> recipient.
>
> We are generally regarded internationally as having a very safe Blood
> Service, especially because of our precautionary approach to screening for
> infection, careful donor selection and the tradition of volunteering which
> means that our donors generally have a lower incidence of many viral
> diseases compared to those in other countries who are paid for their
> donations.
>
> Secondly, as for the wider situation for vCJD, thankfully we have not so
> far seen the thousands of cases of vCJD that some projections suggested.
> As of 1 December 2003 there had been a cumulative total of 143 cases of
> vCJD in the United Kingdom. Over the last three years the annual number
of
> new cases has fallen. However, there should be no complacency. It remains
> premature to conclude that the epidemic has peaked. Any case of vCJD is
> tragic for the patients and families concerned.
>
> I hope that my statement has given the House a clear and accurate account
> of this finding in the full context in which it needs to be seen. I have
> asked the Chief Medical Officer to oversee the further work and
> investigation required and to keep me closely informed. I will of course
> keep the House informed of any major developments in this area."
>
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