DRAFT Minute of Meeting to Discuss the Management of Patients Who Receive Blood from Donors who Later Develop vCJD
16th June 2000, 2.00pm, Room LG17 Wellington House

Attendees

Chairperson

Dr Pat Troop	DCMO

Members

Professor Len Doyal	Ethics Expert, St Bartholomew Hospital
Mrs Jean Gaffin	Lay Representative
Professor Ted Gordon-Smith	CMO Consultant Advisor
Dr David Gorst	MSBT Member, Consultant Haematologist, Royal Lancaster Infirmary
Dr Pat Hewitt	Lead Consultant, Transfusion Microbiology, National Blood Authority
Dr Aileen Keel	Deputy Chief Medical Officer, Scottish Executive Department
Dr Richard Knight	National CJD Surveillance Unit
Dr Cliff Morgan	Chairman, Blood User Group
Rev. Dr John Polkinghorne	Ethics Expert, Queens College Cambridge
Dr Angela Robinson	Medical Director, National Blood Authority
Dr David Taylor	Neuropathologist, Sedecon 2000
Professor Bob Will	National CJD Surveillance Unit
Dr Gail Williams	Welsh Blood Service
Dr Tim Wyatt	MSBT, JWG Representative

Officials

Mr Charles Lister	Blood Policy and Safety, DH
Mr David Dunleavy	Solicitors, DH
Dr Elizabeth Smales	Head, Communicable Disease Branch
Dr Antonia Leigh	CJD/ BSE Policy Unit, DH
Mr Peter Jones	CJD/ BSE Policy Unit, DH
Ms Claire Mills	CJD/ BSE Policy Unit, DH

Apologies Received - Members

Professor Adriano Aguzzi	University Hospital of Zurich
Professor Chris Bostock	Institute for Animal Health
Mr Harry Cayton	Alzheimer's Society
Professor John Collinge	Director, MRC Prion Unit, St Mary's Hospital
Professor John Harris	Ethics Expert, Law Faculty, University of Manchester
Professor Don Jeffries	St Bartholomew's Hospital
Ms Diana Kloss	Lay Representative, Law Faculty, University of Manchester

Apologies Received – Officials

Dr Martin Donaghy	Scottish Executive Health Department
Mrs Gwen Skinner	Blood Policy and Safety, DH
Dr Elizabeth Mitchell	Dep. Of Health, Social Services and Public Safety, N. Ireland
Dr Mike McGovern	Blood Policy and Safety, DH
Dr Ailsa Wight	Head, CJD/ BSE Policy Unit, DH
Ms Chris Warncke	Solicitors, DH

Agenda Item 1: Welcome and Apologies

1. The Chair welcomed the group and thanked them for attending. The apologies were announced.

Agenda Item 2: Current position. Current controls on blood based on SEAC advice

2. Dr Robinson informed the group that donations were excluded from pituitary hormone growth recipients; women who had been treated with pituitary gonadotrophins before 1985; corneal transplant recipients; all individuals who have a family history of CJD and those who have had brain surgery or an operation for a tumour or cyst on the spine before August 1992.

3. Further precautions included leucodepletion of UK blood donations and importing plasma from non-UK sources, although it was accepted that the leucodepletion of blood products was an extra-precautionary measure. The European Committee on Proprietary Medicinal Procedures (CPMP) had also advised that any plasma product containing donations from a vCJD donor should be recalled.

4. In October 1999 the NBA had received instructions from the Department of Health to 'flag' those who have received blood from a donor who later developed vCJD to prevent their blood from entering the supply. The NBA had currently been notified of 13 people in England in this category. Of these, three were in the age group eligible to present as donors. There was also 1 person in Scotland who had received implicated blood and was eligible to donate.

Agenda Item 3: Scientific Assessment of Risk

<u>Tests on Blood from Human CJD Cases</u>

5. Professor Will explained to the group that four studies had been performed which examined the infectivity of blood components (i.e. whole blood, concentrated plasma or buffy coat) from sporadic or iatrogenic CJD patients by intracerebral inoculation of rodents. Infectivity was detected in the receipt animals (mouse, hamster or guinea pig)

6. However there had been a number of concerns raised regarding the scientific validity of these tests, all involving very few animals. The concerns were reviewed in Brown 1995.

7. In addition several other studies have failed to show infectivity in the blood of sporadic CJD or Kuru cases when inoculated into primates (monkeys or chimpanzees). Examination of all these studies have been taken to indicate the possibility of infectivity in sporadic and iatrogenic CJD blood at a low level.

Variation of Infectivity in Blood Through the Incubation Period

8. Several animal TSE studies had been performed on blood, all with varying results. Pattison and Millson (1962) examining experimental scrapie agent in goats showed no infectivity in blood. Diringer (1984) indicated a relatively high level of infectivity up to 40 days but no information on the later period. Casaccia et al (1989) indicated a high level of infectivity and a subsequent decline. Manuelidis et al (1978) indicated infectivity varying throughout the incubation period, with the highest infectivity at the clinical stage. Kuroda et al (1983) showed infectivity increasing towards the end of the incubation period.

9. Several epidemiological studies have reviewed CJD cases to investigate whether they may have resulted from blood transfusion. Studies in the UK and USA have shown that CJD patients have no more than average exposure to blood transfusions or blood products.

10. A collaborative study between the NCJDSU and the UK Blood transfusion Services has been in progress since 1997 to examine the possibility of transmission of CJD via blood transfusion. Patients with sporadic CJD and matched controls, who were reported to have donated blood, were identified and a single look-back exercise was performed. The details of the recipients who received components from these donors are held in the NCJDSU database in order to check whether any subsequently develop CJD. This process was extended to vCJD cases. So far, 30 recipients have been identified in the CJD study and 12 in the vCJD study. None has appeared as suspect cases on the NCJDSU register.

11. A reverse TMER study had been performed, which looked at CJD patients and matched controls with a history of blood transfusion, to establish whether the patients had ever received blood from a suspect source. There was no evidence that this had occurred. No CJD patient had received blood from a donor who was suffering from, or later developed, CJD.

12. The agent for vCJD appears to have a more lymphoreticular involvement than sporadic CJD and may be associated with circulatory B lymphocytes and with other cells of the immune and circulatory systems. Therefore infectivity in blood may be more likely or higher than in sporadic CJD. It would therefore be unwise to assume the two diseases behave in the same way regarding blood. The group agreed that although the scientific evidence was not powerful, there were grounds for concern regarding the risk of transmission of vCJD via blood or blood products.

Agenda Item 4: Background on current position on exclusion of donors who may have received blood from a donor who later develops vCJD

13. Dr Hewitt informed the group that the NCJDSU notifies the NBA of any new probable case of vCJD. If any donations had been received from that person, the NBA notifies fractitionors and traces the rest of the components to recipient level.

14. Because none of the patients who had received implicated blood were currently blood donors, they had been pre-registered as donors on NBA's database and then "flagged". The flag would become active once a donation was received at the laboratory. This system had been adopted as donation units were very open, making it difficult to refuse blood donations discreetly at the time of donation.

15. The current situation was that, if a flagged donor presented, a donation would be taken on that occasion but not used. The NBA would then seek to inform the individual that his/her blood could not be used, and explain the reason. It would not be acceptable to continue accepting donations and discarding the blood. MSBT had discussed how this situation could be managed, but had not specifically considered whether the risk justified excluding these donors, and a scientific evaluation of the risk did not appear to have been undertaken at any stage.

16. It was the NBA's policy to inform donors when other diseases, such as HIV are found in their blood donation. The NBA then offers advice and counselling to the donor.

Agenda Item 5: Ethical Issues/ Considerations

17. Many members of the group expressed concern at informing the recipients of uncertain and unquantifiable risk, when there is no method of evaluating the risk to which they had been exposed and no means of therapeutics, test or treatment. This opinion was enhanced by the fact that the disease has a long incubation period, and would impose a long period of uncertainty and anxiety. It was suggested that in these instances it would be unethical to impose such knowledge on patients.

18. Some members of the group agreed that the uncertainties regarding the risk would cause distress and concern in the patients. There was evidence of suicides resulting in comparable situations where patients had been informed that they had been exposed to an unknown risk. In comparison to this, some members believed that distress would also be produced if patients were not informed, and then later discovered that information regarding their health had been kept from them.

19. Some members approved the 'flagging' approach, in the event that a test should be developed, in which case the patient could be informed and undergo the test to determine the risk to their health.

20. The group discussed how 'the right to know' should be balanced with 'the right not to know'. There was some evidence that in comparable situations the majority of the population would prefer not to be informed. For example, in a survey 80% of people stated that they would like to be tested for Huntingdon's Disease if a test became available, but only 18% presented for the test when they were presented with the option. However, it was suggested that it would be difficult to provide the option 'not to know' without first providing some facts to the patient.

21. Members of the group believed that there was a need to increase the public's awareness of the disease and to educate them regarding the risks. This would mean that the theoretical risk of contracting CJD via blood products could be accepted with other theoretical health risks, such as the risk from exposure to X-rays.

22. The group also agreed that the knowledge of a risk to health could have practical implications on life decisions, such as the decision to have children. It could also have some negative implications, such as increasing health/life insurance premiums.

23. It was stated that the assumption is made that adults are competent to receive information regarding their health. It would be dangerous to assume that adults who have received blood from donors who later develop vCJD are not competent to understand and accept the risk of vCJD via blood products.

24. Mr Dunleavey informed the group that the Data Protection Act states that a patient has a right to information regarding them. There was a duty to inform patients of a risk to their health, except in those cases where doing so would cause harm to the patient. This decision was to be made by the clinician responsible for the patient.

Agenda Item 6: Discussion

25. The Chair stated that there were three broad options for the group to decide:
    i. To inform
    ii. Not to inform
    iii. To provide an option to be informed

26. It was stated that the possibility of a diagnostic test to detect vCJD was not likely in the foreseeable future and decisions should not be made based on the possibility of a test becoming available. Also, any decisions made by the group would set a precedent for other areas of informing patients. It was therefore necessary to ensure that all options and decisions were carefully evaluated.

27. The group agreed that there was a need for scope for clinicians to decide if it would be suitable to inform a patient. It was also suggested that the rights of the individual patient could be overridden, if they posed a risk to the general population.

28. Some members of the group believed that there was a need to be uniform with any decision made, (i.e. if the decision is made to inform, then all 13 people should be informed, not just those eligible to present as donors). Others felt that the risk would vary from one person to another, and that there was an argument for considering on a case by case basis.

29. It was stated that the whole population of the UK had been potentially exposed to the theoretical risk of vCJD via exposure to BSE. It could be argued that it was illogical to accept blood from the unknown number of people who might be incubating the disease following exposure to BSE, and not from those people who posed no greater risk. Conversely it could be argued that if donations were not accepted from those three, we shouldn't accept any UK-donated blood. The NBA informed the group that this possibility had been investigated, and whilst it would be ideal to source all blood products from non-BSE countries, this was not practical.

30. It was questioned if it could be possible to exclude all transfusion recipients from presenting as donors, as this would prevent the suspected patients' blood from entering the blood supply. The NBA had considered this option, and concluded that this would result in a loss of 10% of the blood supply. This loss could result in losing patients due to a lack of availability of blood.

31. It was suggested that a leaflet could be provided at each donor session, which would explain the risks of transmitting vCJD via blood transfusions. The leaflet could include a 'tick box' where patients could decide if they would wish to be informed if they had received blood from a donor who later developed vCJD. This method had the benefit of allowing patients to make an informed decision. However, some members of the group expressed concern that this might pose ethical problems because the leaflet may not reach every donor and that some people may not read the leaflet.

32. The group was informed that prior to donating blood, questionnaires are completed regarding the donor's medical history. It was suggested that a question could be built in to the existing questionnaire, which would identify patients who had received blood transfusions. This method could be devised in a way that left scope for patients to make an informed choice regarding whether they would like to be informed of a risk to their health. It would also be possible to perform using existing paperwork and routines. However, this method would only identify those patients who presented as donors and it was also suggested that some donors may not be aware that they had received a blood transfusion.

33. The group agreed that if this method were adopted, there would be a need to explain to the patient that their blood could be rejected for a variety of reasons, which could be very minor, or alternatively could pose major health implications. The group also agreed that full counselling should be made available to the patient if they make the decision to be informed.

34. It should also be explained to the donor that their blood could be refused if the donor whose blood they had received was subsequently found to have developed one of a range of illnesses.

35. The group agreed that, providing the above points were included, that this method was the most suitable for addressing the problem.

Agenda Item 7: Conclusions

36. The group reached the following conclusions:

- The NBA should draft a protocol for identifying recipients of blood from vCJD donors if they come forward as donors, and making information available for those who want it.

- The NBA would put the draft to the group for comment. A further meeting of the group would be arranged if necessary.

The ten recipients who were not eligible to present as blood donors had not been traced and it was felt that they did not need to be informed. However, although they were not eligible to present as blood donors there was a potential for them to be organ donors. This remained an important issue, which needed to be thought through.

References

1. Brown (1995) Can CJD be transmitted by transfusion? Current Opinion in Haematology, vol. 2, 472-477

2. Casaccia et. al. (1989) Levels of infectivity in the blood throughout the incubation period of hamsters peripherally injected with scrapie. Arch. Virol. 108, 145-149

3. Diringer (1984), Sustained viremia in experimental hamster scrapie. Arch. Virol. 82, 105-109

4. Kuroda et al. (1983) Creutzfeldt-Jakob Disease in mice: persistent viremia and preferential replication of virus in low density lymphocytes. Infect. Imm. 41, 154-161

5. Manuelidis et. al. (1978) Viremia in experimental Creutzfeldt-Jakob disease. Science 200, 1069-1071

6. Pattison and Millson (1962) Distribution of the scrapie agent in the tissues of experimentally inoculated goats. J. Comp. Path. 72, 233-244