50

Dr Waiter

cc Dr Maycock
Dr Raison
Mr Draper
Mr Cleasby
Mrs A D Johnson
Mr Paul Allen
Mrs Maunsell
Mr R N Roberts - SHHD
MrsS G Evans - Welsh Office

TESTING FOR HEPATITIS B SURFACE ANTIGEN AND ITS ANTIBODY

1. The second Report of the Advisory Group was approved by the Minister of State in October last and endorsed by SMAC at their meeting on 11 November. It was then decided to consult outside bodies about the terms of an accompanying Circular and the following were approached:-

BMA
RHA Multidisciplinary Panel
PHLS
IMLS
ACP
RC Path
RCGP
JCC
Staff Side, General Whitley Council
Regional Transfusion Directors

2. Eight Regional Health Authorities have replied and all the professional bodies except the JCC. No reply has been received from the Staff Side.

3. Both the JCC and the Staff Side are again being asked whether they have any comments. The undermentioned had no comments to offer or expressly stated that they accepted the Report and draft Circular without amendment:-

Royal College of General Practitioners
Association of Clinical Pathologists
Royal College of Pathologists
BMA
Mersey RHA
West Midlands RHA

4. The following is a summary of comments received. (The reference number is to the papers on file H/B23/94H).

105A. Northern RHA

It is suggested that the circular should draw the attention of AHAs to their responsibility for informing staff of the potential risk and the need for care when handling specimens of blood or blood products.

104A. Dr Maycock's summary of comments of MO'Ds

Some Directors express reservations about discontinuing (with prescribed safeguards) the practice of excluding from the panel donors with a history of jaundice but the majority favour admitting such donors from a given date.

102A. South East Thames RHA

Reservations about including or readmitting donors with a history of jaundice.

101A and 100A - North Western RHA

(i) The proposal that where antenatal specimens are sent to the RTC for blood grouping, they may also be tested there for $HB_sAg$ if the Director agrees, will require detailed consideration as to the lines of communication and the action required in dealing with positive cases in ante-natal women.

(ii) The relevance of the more sensitive radio immuno assay techniques should be stressed as a routine in relation to testing of blood for $HB_sAg$ for use in renal transplant units in view of depressed immunity.

(iii) Differential notification should be introduced if the practical difficulties can be overcome.

(iv) The testing of specimens for biochemical values (often done on a machine) would not always be possible under "hepatitis laboratory conditions".

(v) Reservations about the construction which might be placed on para 37 which it is felt might be construed that family doctors should routinely take liver function tests of all antigen carriers; and the observation that serious hepatic pathology can exist though liver function tests are normal. Suggests that samples should be taken when the patient is referred to the hospital.

(vi) Suggests that the report should state that where carriers are employed in medical or paramedical duties, these should be reviewed in the light of the positive findings.

(vii) Suggests that the patient's antigen status should be recorded in his documents, including F.P's document folder.

99A - North Western RHA

It is suggested that the circular should refer to the need to screen staff who handle specimens from patients who are $HB_sAN$ positive at regular intervals.

98A and 107A - South Western RHA

(i) It is stated that there are no biochemical laboratories with facilities to the high standard in Somerset. It is suggested that a list of specialised laboratories throughout the country should be sent to general practitioners and pathologists.

(ii) Comments on the risks to laboratory staff and suggests that DHSS hold discussions with the "technicians' Institute" and with their trade union representatives without which the Somerset AHA are not prepared to order their technicians to undertake examination of these specimens.

(iii) Reporting the views of the Bristol Health District the Authority write:

'The consultant staff here are unlikely to agree with the Committee's definition of 'high risk' patients. The medical opinion I have received is to the effect that this category of patients is unnecessary, as such patients are frequently tested in any case and that the Committee's category (ii) is too broad and their category (iv) is too vague. Dr Speller, Consultant Bacteriologist here, points out that in the latest edition of the Medical Staff handbook in use in the District other minor 'at risk' groups are defined and it may well be

that comment could be made that the Department should consider the appropriateness of the categories of patients as set out in para 68.'

91A - S W Thames RHA

Comments from the Regional Transfusion Director about the staffing implications and washing facilities.

90A - The Institute of Medical Laboratory Sciences

Suggest a drafting change to improve clarity and emphasis.

72A - Oxford RHA

Question the necessity of testing all staff.

5. The above does not purport to be a complete account of all the comments received but is intended to show the general line of thought and the weight of opinion expressed. Those consulted have in many instances not confined their comments to the draft circular but have commented on the report itself. The two main areas of concern seem to relate to the safety of staff handling infected material and the misgivings in some quarters about opening the donor panel to persons with a history of jaundice.

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