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MSBT 3/12

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ADVISORY COMMITTEE ON THE MICROBIOLOGICAL SAFETY OF BLOOD AND TISSUES FOR TRANSPLANTATION

MINUTES OF THE THIRD MEETING HELD ON 29 SEPTEMBER 1994 IN ROOM 124A SKIPTON HOUSE

Chairman:	Dr J S Metters
Members:	Dr A Cant Dr D W Gorst Dr P McMaster Dr R Mitchell Dr P Mortimer Dr A Robinson Dr T Snape Dr R E W Warren Professor J D Williams Professor A Zuckerman
Observers:	Dr A M George Dr G Mock Mr P Pudlo Mr J S Sloggem Mr G Tucker
Secretariat:	Dr A Rejman [redacted]

1. Chairman's Introduction

The Chairman welcomed two new Members, Dr Angela Robinson (NBA Medical Director) and Dr Terry Snape of the Bio Products Laboratory, and [redacted] to the Secretariat.

2. Apologies for absence

Apologies for absence were received from Miss Lord, Dr Perry and Dr Keel.

3. Minutes of the second MSBT meeting - 10 February 1994 (paper MSBT 2/4).

Members had no comments on the minutes of the second meeting, which were agreed.

4. Matters arising from these minutes, not dealt with as separate items:-

- minute 4.1: combined HIV and HTLV test

4.1 Dr Robinson gave a verbal report on the Launch Biokit HIV1 and 2 and HTLV 1 and 2 antibody assay at Leeds Regional Transfusion Centre. Professor Zuckerman expressed concern about examining a test which had shown variation in specificity from batch to batch. A paper was being prepared for consideration by SACTTI on 19 October. The Committee agreed to defer decision on this item until the next meeting of MSBT, when the paper would be available to it.

- minute 4.2: guidelines for reporting the transmission of Yersinia by blood - Dr Mitchell's paper on bacterial contamination of blood and blood products (paper MSBT 3/1)

[redacted]

- minute 4.3: routine screening of blood and tissues /organs for anti-HBc (paper MSBT 3/2)

[redacted]

- minute 4.4: dura mater

[redacted]

- minute 4.5: tissue banks (paper MSBT 3/9)

5. HIV 0 (paper MSBT 3/3).

5.1 Dr Mortimer introduced paper MSBT 3/3 and described HIV 0 as diverse HIV strains not falling into known strains. Cases had been reported in West Central Africa and France, but there were no known cases elsewhere in Europe. Some test kits had failed to detect HIV 0 in a minority of cases. One of the kits had not been allowed on the UK market because of other concerns about its accuracy. Abbott and Murex had both made modifications which they claimed overcame the problem. Dr Mortimer explained the difficulty in obtaining the serum for PHLS to evaluate these claims. There was still doubt as to whether the modified kits were as sensitive to HIV 1 and 2 as current kits, but the risk of HIV 0 occurring in his country was considered to be very small.

5.2 The Committee agreed that HIV 0 did not represent any significant risk to the blood supply and did not justify any change to present arrangements. The Committee agreed to keep HIV 0 under close review.

6. HCV look back (paper MSBT 3/4).

6.1 Dr Robinson introduced paper MSBT 3/4 covering the SACTTI recommendations for considering look back for HCV. In the view of SACTTI the position had changed since 1991, when HCV screening was introduced, but not HCV look back. Factors in support of the SACTII recommendation included the impact of earlier diagnosis on treatment and care, and evidence from pilot studies of viral clearance by interferon and ribavirin combination therapy. The National Blood Service had the facilities to undertake tracing, counselling and referral, and the potential caseload was estimated at 3,000 for England and Wales.

6.2 Dr Zuckerman said that 60% response to interferon was a grossly exaggerated figure. The Luxembourg study showed a

response rate of around 20% and figures from the Royal Free showed a response rate of 20 to 25% in carefully selected patients. In studies in Italy and Taiwan it was shown that under the best conditions up to perhaps 40% responded to interferon at least temporarily. HCV infected blood transfusion recipients would be a small proportion of the HCV infected population. Interferon was not licensed for treatment of HCV related disease, and its side effects were unpleasant. The Chairman confirmed that the Committee should not recommend to Ministers the use of a drug outwith its licensed indication. Professor Zuckerman said that interferon would in any case be costly with little clear evidence of clinical benefits. Ribavirin was even more costly. There was also considerable potential for litigation associated with HCV lookback.

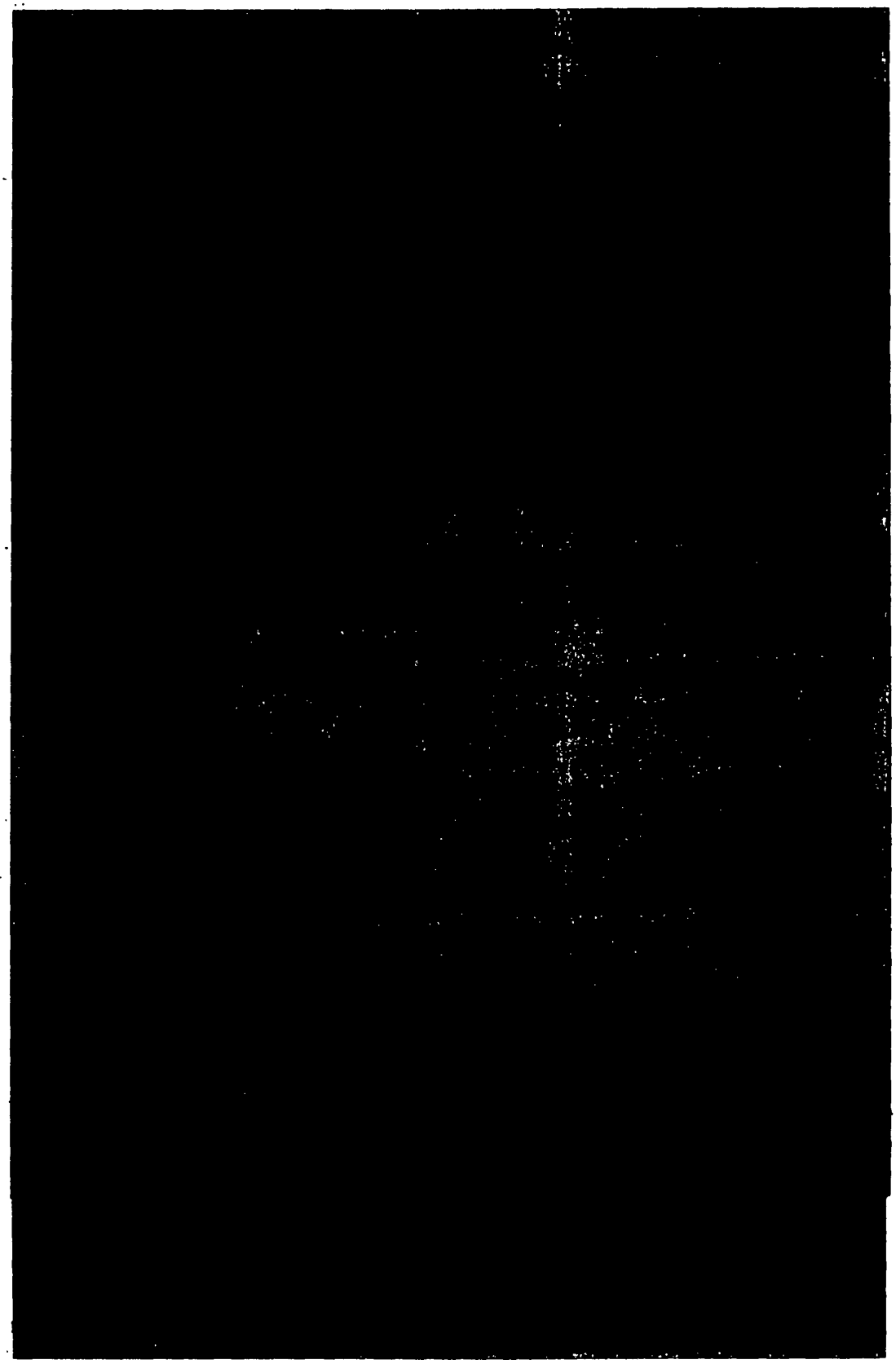
6.3 Dr Zuckerman said that there was however a strong argument for lookback in the case of younger blood transfusion recipients. Dr Cant said that younger patients showed a good response rate if treated early. Dr Warren thought there might be an epidemiological case for following a cohort with an actual history of HCV related disease. Mr McMaster said that in the West Midlands discussions on HCV lookback were well advanced and that there was an obligation to identify those affected.

6.4 Mr Tucker said that approaches to institute HCV lookback in Scotland had been resisted, and it was important that a UK wide approach was adopted. Dr George and Dr Mock said that WO and DHSS NI were also in favour of a UK wide policy on HCV lookback. Dr Rejman said that there had been difficulties in tracing back in the context of the Scheme of payments for those infected with HIV through blood and tissue transfer because of deficiencies in hospital recording. There also appeared to be variation between centres in the treatment given to HCV positive haemophiliacs.

6.5 Paper MSBT 3/10 covering SNBTS paper on HCV lookback was tabled.

6.6 It was agreed that Members would submit written comments during the next three weeks and that Dr Robinson, Dr Gorst and Professor Zuckerman would form the core of a group to consider Members comments in time for the next meeting of the Committee.

7. Promoting the safety of transplantation of human tissues and organs (paper MSBT 1/4 of the meeting of 4 October 1993 and paper MSBT 3/5).



[redacted]

8. EC activities relevant to the Committee:-

- EC Directive on blood products (pituitary gonadotrophins)

8.1 Mr Sloggem reported that the WHO had now incorporated exclusion criteria for recipients of human pituitary extracts, which the Council of Europe was expected to agree in October. The European Pharmacopoeia had included the exclusion criteria in the revision of the monograph on Plasma for Fractionation.

8.2 Mr Sloggem also reported that two groups had been set up to advise CPMP, a Sub-Committee on Clinical Aspects Related to Medicinal Products Derived from Human Blood or Plasma and the Biotechnology/Pharmacy Sub-Group on Medicinal Products Derived from Human Blood or Plasma.

the latter group were considering:

requirements for inactivation/removal of viruses from blood products;

inspection and audit of donation centres;

criteria for donor selection, screening and exclusion;

procedures in different Member states for licensing and selection of kits used to test donations for markers of infection;

review of intravenous immunoglobulins;

programme to improve safety of blood products with respect to non enveloped viruses;

Batch release guidelines had been agreed which included testing of plasma pools for HBsAg and antibodies to HIV1 and 2 and hepatitis C.

9. ALT testing of blood donations (paper MSBT 3/6)
(paper MSBT 3/7)

9.1 Dr Robinson introduced paper MSBT 3/6, the revised report of the NBS working group on ALT testing of plasma, and said the NBA accepted that introduction of ALT testing of blood donations would do nothing to aid the safety of the blood supply. The need to meet clinicians' demand for factor VIII was the driving force behind the quantity of plasma for fractionation, leaving a surplus of albumin and immunoglobulin. The NBA planned to supply this surplus to Europe, which had a 50% shortfall in supply of these products.

The NBA had found that although ALT testing of plasma was not an EC statutory requirement, several European countries demanded ALT testing of the plasma used in fractionating these products. Some albumin had been supplied to Europe on an individual import licence basis to meet shortages, but the NBA wished to register surplus albumin and immunoglobulin for long term import licence which could not be achieved without ALT testing. Benefit to the NHS was estimated at £14 million. If the surplus products or the fraction paste containing them could not be exported the only option was to destroy them.

9.2 All donations would need to be tested, whether they are used for plasma fractionation or not. In the case of donors with ALT levels greater than 160iu per litre or consistently above 100 iu per litre, there may be some liver disease or malfunction. High ALT levels presented no risk to the blood supply, but the concern would be for the donor, how the donor should be counselled and how introduction of ALT testing should be presented publicly.

9.3 Dr Mitchell said that the difficult question was whether or not the donor should be notified of a high ALT level. The only purpose of ALT testing would be for export. There was no perceived benefit to donors, who had not been consulted. Scotland did not export and Dr Mitchell did not think that Scotland would wish to introduce the test. Dr Perry's letter of 29 September 1994 which was tabled (MSBT 3/11) emphasised the need for a common UK approach.

9.4 Mr Sloggem reported on the situation in Europe; MSBT 3/7 covering the MCA paper on ALT testing was tabled. Dr Snape said that the demand for ALT testing in Europe would continue and that disparity between member states was affecting achievement of self sufficiency by preventing movement of these products across national boundaries.

9.5 Members found it difficult to see why the Committee should recommend introduction of ALT testing if NBS assurances were that ALT was not harmful to the blood supply. On the other hand they recognised the arguments against destruction of the surplus products. The Chairman said that DH would be unhappy with a view which was not UK wide. Mr Tucker said that Scottish Office would be concerned about the possible effect on the donor base. Dr Mock echoed the Scottish office concern and stressed the importance of the UK context. Donors in Northern Ireland would find it difficult to understand introduction of ALT testing in England, but not Northern Ireland.

9.6 The Committee agreed that in view of the problems of counselling donors, the potential effect on the voluntary donor system and the need for a UK wide policy, it could go no further than to reaffirm its position that there was no public health benefit from introduction of ALT testing. The Chairman said that the view of the Committee would be put to Ministers to consider along with the other policy considerations

surrounding the introduction of ALT testing of donations.

10. Quarantining of FFP for clinical use (paper MSBT 3/8)

10.1 Dr Robinson introduced paper MSBT 3/8, the SACTTI's recommendations for a quarantine period for clinical fresh frozen plasma and cryoprecipitate and sought the Committee's agreement in principle to the recommendation, which offered a relatively simple way of locking out the seroconversion window period. Dr Mitchell supported the proposal as long as it was logistically feasible; for example, storage of 6 to 7 months supply could be difficult. Dr Warren supported the proposal on microbiological grounds, and said that in the interests of safety it seemed illogical not to take this step. Dr Snape said that following the UB plasma incident, there were moves in Europe to apply quarantine period for plasma for fractionation.

10.2 The Committee agreed to approve the SACTTI recommendation principle, and to consider at a subsequent meeting the more detailed proposals which SACTTI would put forward for quarantine period and timescale for its introduction.

11. Any other business.

11. There was no other business.

12. Date of next meeting.

12. The next meeting of the Committee has been arranged for Thursday 15 December at 2.00 pm in Room 310 Eileen House.