

PROPOSED REVISION
(FINAL EDITION)NATIONAL BLOOD TRANSFUSION SERVICEGUIDANCE FOR THE SELECTION, MEDICAL EXAMINATION AND CAREOF BLOOD DONORSSECTION I - SELECTION OF DONORS

1. Donors should be healthy people of either sex over 18 years of age. New donors will be welcome up to the age of 60, regular donors can continue to donate up to the age of 65.

Potential donors who are under about 50 kg (8 stone) body weight are more likely to faint or suffer other adverse reaction to normal blood donation and should therefore be dissuaded. If they have already donated uneventfully they may still be accepted (some Regions accept part donations from underweight donors to produce serum for laboratory use).

Healthy people as above can generally donate up to 450 ml of blood (plus small laboratory samples) without any deleterious effect on their health or resistance to disease, and with only a temporary effect on the circulation from which recovery is rapid. Donors should have had a meal within a few hours prior to donation (see also Section III 5).

2. Interval between donations. It is the policy of the Service to maintain donor panels at a size which ordinarily will not require donors to give more than 2 donations in a year (min. interval 16 weeks). Any donor (male or female) who recurrently fails the haemoglobin test should be critically reviewed with regard to future donation.
3. THE DECISION WHETHER OR NOT A PERSON IS FIT TO GIVE BLOOD RESTS FINALLY WITH THE DOCTOR HAVING DUE REGARD FOR THE WELFARE OF DONORS AND THE SAFETY OF RECIPIENTS. PARTICULAR CARE SHOULD BE EXERCISED WITH ALL OLDER DONORS. Patients referred for therapeutic venesection should not be accepted at donor sessions.
4. Hazardous occupations. Arrangements for sessions at factories should take account of the type of work being performed and where possible, arrangements made for staff whose work is hazardous to be bled at the end of their working day or shift.

At all sessions special note should be taken by the Medical Officer of the occupation of the donor and any hazardous hobbies; donors should be advised to postpone donation if in the next few hours they will be working as civil air crew, a train or bus driver, heavy machinery or crane operator, one climbing ladders or scaffolding, diver etc; or taking part in hazardous hobbies such as gliding, power flying, motor car or cycle racing, climbing etc.

Queen's Regulations for the Royal Air Force para. 900 (28.1.76) state that aircrew personnel, RAF or WRAF, whether trained or under training are ineligible to act as blood donors except in emergency. The donation of blood by aircrew will normally entail their removal from flying duties for seven days.

SECTION II - MEDICAL EXAMINATION OF DONORSMedical History

A donor is the best judge of his or her fitness, and truthful answers to simple questions about his or her medical history and general health form a large part of the assessment.

The donor session clerk should specifically question the donor about the conditions listed on form NBTS 110A and request the donor's signature on form NBTS 110. Any conditions declared should be recorded by the Clerk or preferably by the Medical Officer, most conveniently in the "medical history box" on the NBTS 101 donor record card or other equivalent document.

A suggested layout of NBTS 110A (Revised 1983) is attached. This, or similar notice should have printing sufficiently large and clear so that donors can read it comfortably. The notice can conveniently be mounted on card and covered for repeated use.

A more detailed list follows of conditions which may affect actions taken with a particular donor, whether to accept a donation, to refer the donor to the Medical Officer or to decline their offer permanently. Any donor not accepted because of one of the conditions listed will, if they ask, be referred to the Medical Officer.

<u>CONDITION</u>	<u>ACTION</u>	<u>COMMENT</u>
Abortion, (see pregnancy)	Wait	See note xii
Accident, minor	Wait	See note vii
" major	Wait	See note viii
Acupuncture	Wait	See note vi
Allergy	Refer to MO	See appendix 1
Anaemia	Refer to MO	See appendix 1
Blood donation within 4 months	Wait	See section I, 2
Blood transfusion in last 6 months	Refer to MO	See note ix
Brucellosis	Disqualify	
Cancer	Disqualify	
Contact with infectious fevers	Wait	See note ii
Contraceptives - oral, the "pill"	Accept	See note xi
Creutzfeld - Jakob disease	Disqualify	See appendix 1
Dental treatment	Refer to MO	See note x
Diabetes mellitus	Refer to MO	See appendix 1
Drug abuse	Disqualify	

3.

<u>CONDITION</u>	<u>ACTION</u>	<u>COMMENT</u>
Drugs - prescribed by Doctor - self-medication (eg aspirins)	Wait, or refer to MO	See note xi
Ear-piercing - see piercing of ears etc	Wait	See note xi
Epilepsy	Refer to MO	See appendix 1
Gastrectomy	Disqualify	
Glandular fever	Wait	See appendix 1 (infectious mononucleosis)
Hay fever	Refer to MO	See appendix 1 (allergy)
Heart disease	Disqualify	
Heart operations	Refer to MO	See appendix 1
Hepatitis	Refer to MO	See appendix 1
High blood pressure	Disqualify	See appendix 1 (hypertension)
Homosexuals (self-declared)	Refer to MO	
Infections - boils, sore throat etc	Wait	See note iii
Infectious fevers - recent measles mumps etc	Refer to MO	See appendix 2
Infectious mononucleosis	Wait	See appendix 1
Inoculations	Wait	See below
Jaundice	Refer to MO	See appendix 1 (hep- atitis)
Kidney disease	Refer to MO	
Malaria	Refer to MO	See appendix 3
Multiple sclerosis	Disqualify	
Piercing of ears etc	Wait	See note vi
Pregnancy	Wait	See note xii
Stroke	Disqualify	
Surgery minor	Wait	See note vii
Surgery major	Wait	See note viii
Tattooing	Wait	See note vi
Thyroid disease	Refer to MO	See appendix 1

4.

<u>CONDITIONS</u>	<u>ACTION</u>	<u>COMMENTS</u>
Toxoplasmosis	Refer to MO	See appendix 1
Tropical diseases filariasis kala azar leptospirosis Q fever Yaws	Disqualify	
Others	Refer to MO	See appendix 3
Tuberculosis	Refer to MO	See appendix 1
Undulant fever (syn. brucellosis)	Disqualify	
Underweight less than 50 kg (8st)	Disqualify	Except in some Regi see also Sections I 1, and III, 5.
Venereal diseases	Disqualify	See appendix 1

Notes on some of above requiring deferral:-

<u>i.</u>	<u>Inoculations</u>	<u>Time since event before donations accepted</u>
	<u>Live vaccines</u>	
	Rubella	3 months
	B.C.G. Measles, Mumps, Polio - live oral; Rabies smallpox, Yellow fever))) 3 weeks providing donor feels well
	<u>Killed vaccines/Toxoids</u>	
	Hepatitis B	6 months
	Anthrax; Cholera; common cold; Diphtheria; Influenza; Polio- (Salk); Tetanus; Typhoid (TAB)))) 1 week providing donor feels well
ii.	Contact with infectious fever if donor has not already had the illness.	Incubation period, or if unknown, 4 weeks.
iii	Intercurrent infection - boils, sore throats, skin infections etc	Until cured

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iv	History of hepatitis, jaundice	12 months, but see appendix 1 under 'hepatitis'
v	Infectious mononucleosis (glandular fever)	2 years
vi	History of tattooing, acupuncture or piercing of ears etc. in the last six months	6 months
vii	Minor surgery or accidents	about 1 month
viii	Major surgery or accidents admitted to hospital)	6 months minimum depending on nature of disease or injury
ix	Transfusion of blood or blood products received in last six months)	
x	Dental treatment	48 hours (because of possible bacteraemia), but one month minimum if general anaesthetic given
xi	Prescribed treatment with antibiotics antihistamines, antidepressants, non-steroid anti-inflammatory drugs etc (see also end of Section II), but excluding oral contraceptives, (the "Pill") and similar hormone treatments.	1 week minimum after treatment finished
	Self medication with non-prescribed drugs e.g. aspirin (v. common, often undeclared)	3 days, preferably longer. (Some Regions discount altogether unless donations to be used for platelet preparation).
xii	Pregnancy (see also Serum Donors, below)	
	Gestation of six months or more	1 year following delivery
	Abortion (spontaneous or therapeutic) up to six months gestation	6 months minimum from termination of pregnancy

On each subsequent occasion the donor should be shown the notice NBTS 110A and asked to sign form NBTS 110 to show that he/she had read it.

Serum Donors. In certain circumstances, e.g. to collect serum containing valuable antibodies, mothers may donate within the recommended time since confinement if shown by medical examination to be fit to give blood. Under these circumstances it might be wise to withdraw less than the usual amount of blood. Special arrangements for the donation should be made with the agreement of the attending Obstetrician or family doctor if the donation is being taken within six weeks of confinement. Plasmapheresis rather than simple donation is to be preferred wherever possible.

6.

Donors both male and female, whose serum or plasma is to be used only for laboratory purposes because it contains anti-Rh, anti-HLA, etc. should be submitted to the same routine as other donors, but because the blood is not going to be transfused some decisions, especially about temporary deferral, may be modified, e.g. treatment with certain tablets, or an attack of hay fever need not disqualify, etc. All such donors should be informed that their blood is to be used in this way and their agreement should be obtained.

EXAMINATION OF THE DONOR

1. Haemoglobin estimation. The haemoglobin should be determined each time the donor presents. Female donors with less than 12.5 g/dl, or male donors with less than 13.5 g/dl should not be bled. The type of test used is left to the discretion of the Regional Transfusion Directors, but the Phillips - Van Slyke copper sulphate method (Reference: J. Biol. Chem. (1950) 183-305) is still widely used as a screen test, sometimes supplemented by a photometric haemoglobin estimation. Both tests are performed on a sample of blood commonly obtained from a finger.

Donors whose haemoglobin appears to be below the appropriate level should be told that it is not advisable for them to donate blood that day. If a more exact determination is not immediately available, a sample of venous blood should be taken into sequestrene for proper laboratory assessment. Donors with haemoglobin levels substantially less than those given above should be advised to consult their own doctors who should receive a report of the results obtained.

2. The medical history should be coupled with a careful assessment of the donor's appearance. The experienced doctor can detect many potentially unsuitable donors at a glance. Those of poor physique, the debilitated, the undernourished, the mentally unstable and those bearing obvious stigmata of disease should not be bled.

Middle-aged and older donors have an increased risk of acquired cardiovascular disorders. Whilst most donors may be accepted on the basis of medical history, general appearance and haemoglobin estimation, it is advisable to examine the pulse and check the blood pressure where there are any doubts, particularly of new donors (see also Appendix under Hypertension).

NOTE: A complete medical examination including X-Ray examination, electrocardiogram and extensive haematological tests is obviously impractical for normal donors, but the above procedure, used skilfully, will lead to the rejection or deferral of most donors who are unfit to be bled and it should be carried out meticulously. When in doubt it is better to reject or defer, and the Medical Officer should then see that an appropriate entry is made on the donor's record.

In general, only healthy people with a good medical history should be accepted as donors.

"INCIDENT LIST"

It may be found useful to keep a separate record at each donor session

for use at the R.T.C. This should list conditions or circumstances which require decision at the Centre as to the fate of the donation but which, for various reasons, are considered best not entered on the donor's permanent record.

DONORS ON TREATMENT WITH DRUGS

In general, donors receiving courses of prescribed medication should be deferred at least until one week after treatment is completed. This is to ensure that the blood collected is as near normal as possible, and to minimise risks for donors themselves. In some circumstances it may be considered wiser to defer longer, viz. three weeks after the more powerful tranquillisers and for six months after steroids. Donors having continuous hormone replacement therapy should be referred to R.T.C. for discussion with the donor's General Practitioner before being accepted.

Sporadic self-medication with some drugs (e.g. antacids, vitamins etc) need not prevent a donation being accepted. However in general terms, it is better to defer for three days and preferably longer. This is essential if the donation is to be used for preparing platelets which are affected by many of the drugs most commonly taken (see also Section II note xi).

While the Medical Officer may use discretion in accepting or deferring a particular donor who has been treated, it is recommended that appropriate notes should be made and that in any doubtful situation it is wiser to defer.

Illicit drug taking if admitted or suspected should debar.

SECTION III - MEDICAL CARE OF DONORS

Apart from courteous and considerate treatment by all members of the blood collecting team, the donor's medical well-being should be assiduously watched by the Medical Officer and the members of the team while he/she is at a blood donor session.

The donor's medical well-being depends upon:-

1. The use of carefully prepared sterile equipment.
2. Sterilisation of the skin prior to venepuncture, using an approved well-tried method.
3. Immaculate technique of venepuncture. An intradermal injection of local anaesthetic is usually given prior to insertion of the phlebotomy needle into a suitable antecubital vein, preferably avoiding whenever possible any vessels that are overlying or adjacent to an artery. Normally, not more than 450 ml blood plus small laboratory samples should be withdrawn. No matter how experienced the doctor (or in some situations the S.R.N. under an M.O's supervision) he or she will occasionally "miss" a vein. No further attempts should be made without the donor's permission. Any second attempt should only be made on the other arm if at all, and even then only if there is good prospect of a successful venepuncture. In factories it is wise never to use the other arm.

4. The enforcement of a definite routine upon the donor during the resting period after withdrawal of blood. The resting period is of special significance in regard to the prevention of the "delayed faint" (see 5 below).
- (a) The donor should remain recumbent for about 15 minutes either on the bed used for venesection, or on a designated rest bed to which he or she should be assisted by the donor attendant. The donor should then sit up for about 5 minutes and have at least one cup of fluid and a few biscuits. If rest is refused, this should be noted on the donor's record.
 - (b) Before the donor leaves, the site of venepuncture should be inspected. On occasion it is possible to forestall complaints from donors by warning them, for example, of likely bruising. A dressing should be placed over the site of venepuncture.
5. The immediate and considerate treatment of those who faint. A small proportion of donors, variously estimated at 2 to 5% faint. This is usually only a transient episode, but in a few instances may be prolonged and troublesome. The "delayed" faint is potentially more dangerous since the donor may be in the street or back at work; it may then prove very important to be able to demonstrate that the routine outlined in Section III, para. 4 a), b), was followed. Because fainting is sometimes psychological in origin, it cannot always be anticipated. It is more likely to occur in otherwise normal healthy donors who have had little or no food for several hours. Also, donors under about 50 kg (8 st) in weight may not withstand giving a full donation without fainting, and should be discouraged unless they are known to have donated blood uneventfully in the past.

The importance of these measures and the reasons for them must be carefully impressed upon the lay members of the bleeding team. The reputation of the National Blood Transfusion Service and the readiness with which donors will volunteer depends very much upon the standard of medical care given to the donor.

SECTION IV - DONORS : COMPLAINTS AND ACCIDENTS

The need for sympathetic, prompt and thorough investigation of all complaints made by the donors, no matter how trivial, is obvious. Complaints of a medical nature should invariably be investigated by a doctor. The following routine, which has proved of value in practice, is recommended.

1. Minor accidents and any untoward incidents occurring during a blood collecting session, e.g. haematoma, fainting, damage to or loss of, a donor's property, should be noted at the time upon the donor's record card or donor session work sheet. The recording of apparently trivial incidents has, in practice, proved of value as long as two years later.
2. Serious incidents or accidents during blood collecting sessions, or complaints made direct to the Regional Transfusion Centre, should be fully recorded in a book kept for the purpose, together with full notes of all investigations made.

9.

An analysis of complaints and accidents should be made annually at each R.T.C. The following headings have proved useful:

haematoma, cellulitis, thrombosis, accidents due to fainting, dermatitis, unclassified, total; ratio to total number of donors bled; number of accidents serious enough to merit financial compensation, together with, if available, the amount of compensation paid.



APPENDIX

Contents:

1. Notes on certain diseases
2. Infectious diseases and plasma for immunoglobulin
3. Tropical diseases

1. Notes on Certain Diseases

(i) ALLERGY. People who give a history of frequent allergy symptom(s) should not be accepted as donors; otherwise donors need only be rejected if they are suffering from allergy when they present, or are symptom free only because of drugs taken within the past three days.

(ii) ANAEMIA. If a donor has failed the screen test on two or three recent occasions, it is probably advisable to delay further donation for an extended period.

A donor who appears well but declares a history of anaemia attributable to the presence of abnormal haemoglobin (e.g. sickle-cell disease, thalassaemia etc) or to other red cell defects should be deferred so that further information may be sought from the family doctor. Most donors with clinically significant red cell abnormalities will not volunteer as donors anyway. It is not currently realistic to screen the entire donor population for milder forms of these disorders, and provided the would-be donor with a covert red cell anomaly appears to have an adequate haemoglobin level, there is probably little risk to prospective recipients.

(iii) CREUTZFELDT-JAKOB DISEASE. Patients with this disease should not be accepted as donors.

(iv) DIABETES MELLITUS. Both new and established donors who present with diabetes may be accepted only if the disease is controlled by diet alone and they appear otherwise fit. Requirement for any form of replacement therapy should debar (further) donation.

(v) EPILEPSY. Some patients with epilepsy react to minor stress by having fits and it is important that additional risks should be avoided. Anyone on regular medication for epilepsy should not be accepted as a donor. A known epileptic who has not required regular anticonvulsant therapy nor been subject to daytime fits for at least two years, may with discretion be considered as a possible donor, but it should be remembered that a fit may be difficult to deal with during a busy session and can be upsetting to other donors.

(vi) GASTRECTOMY. Patients who have had a gastrectomy frequently have reduced iron absorption thereafter and should therefore be excluded as donors.

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- (vii) HAEMOPHILIA etc. A donor who declares a carrier state of haemophilia or allied disorder may be accepted after appropriate enquiries from the family doctor. Donations from such a person should not be used for the preparation of coagulation products.
- (viii) HEART OPERATIONS. Where surgery has been carried out in early life for correction of congenital malformations, donation may be considered. It should only be accepted after appropriate consultation between the Transfusion Centre and the donor's medical adviser(s).
- (ix) HEPATITIS. Individuals who give a history of jaundice or hepatitis or in whose blood anti-HB_s is present may be accepted as donors providing that they have not suffered from jaundice or hepatitis in the previous twelve months, have not been in close contact with hepatitis or received a transfusion of blood or blood products in the previous six months, and providing their blood gives a negative reaction for the presence of HB_sAg when tested by an accepted sensitive method (e.g. R.I.A.). An approved test for hepatitis B surface antigen should be performed each time a donor is bled; donors whose blood is shown to carry HB_sAg shall be excluded from the ordinary donor panel. They may only be considered for reinstatement under special circumstances and if they have been subsequently demonstrated by appropriately sensitive tests to be persistently negative for known viral markers (HB_c, HB_e) for at least twelve months and have an adequate level (> 1 i.u./ml) of anti-HB_s antibody.
- (x) HYPERTENSION. It is practice in many Transfusion Regions to check the blood pressure of all donors over a certain age - say 45.
- A hypertensive whether under treatment or not should not be bled because of the possible complications which may follow the sudden lowering of arterial tension caused by the withdrawal of blood. If a doctor feels that a patient should be bled for the relief of symptoms, whether from hypertension, polycythaemia or other condition, this should be done in hospital where complications, should they occur, can be dealt with more satisfactorily than at a donor session.
- (xi) INFECTIOUS MONONUCLEOSIS. (Glandular Fever) Most patients recover completely within a few weeks. However, following temporary improvement a few experience relapses even up to a year or more later. In view of this and the known viral cause(s) of this illness, donations should not be accepted until TWO YEARS after the diagnosis has been made.
- (xii) THYROID DISEASE. Donors who are obviously suffering from thyroid disease (myxoedema or thyrotoxicosis) and those who are only maintained in reasonably normal health through regular replacement therapy, should not be bled.
- Donors who have recovered from thyroid operations or radio-active iodine treatment may be accepted provided at least six months have elapsed since any treatment given, they do not require thyroid or calcium treatment, and after consultation with the donor's medical adviser.
- (xiii) TOXOPLASMOSIS. It is not practicable to test for the presence of toxoplasma as a routine and it is not known whether the blood of persons recently ill from toxoplasmosis is infective. It would seem wise not to accept blood from volunteers with a known history of toxoplasmosis until a year has elapsed from the specific antibody (e.g. dye) test becoming negative. A donor who presents giving this history

should therefore be deferred until the appropriate tests or investigations have been arranged through the Regional Transfusion Centre.

- (xiv) **TUBERCULOSIS.** Any donor under treatment or regular surveillance for tuberculosis should not be accepted. For other donors with a history of tuberculosis it is advisable to seek information, with the donor's consent, from their family doctor after which a decision can be made. Where the history is of a short illness perhaps many years previously and no further checking advised, it is probably safe to accept the donor.
- (xv) **VENEREAL DISEASE.** It is not customary to question donors about venereal disease. Information may occasionally be volunteered. A person who is known to have or has had syphilis is unacceptable as a donor (see European Pharmacopoeia Vol 3, 1975). An accepted test for syphilis shall be performed each time a donor is bled; a positive reaction - whether confirmed as genuine or as a persistent false positive, - shall lead to the exclusion of the donor from the panel.

2. Infectious Diseases and Plasma for Immunoglobulin

(i) Inoculations and Vaccinations

A dangerously high haemolysin titre may follow the injection of diphtheria or tetanus toxoid, diphtheria antitoxin, or T.A.B. vaccine because these agents sometimes contain blood group substance A. An interval of 3 weeks should elapse between injections of diphtheria antitoxin and blood donation to allow elimination of most of the foreign protein from the donor's circulation and thus avoid the risk of sensitizing the recipient.

(ii) Plasma for Immunoglobulin

(a) Convalescence from infectious disease

Plasma from donors who have recovered within the previous three months from any of the following infectious diseases:

Chickenpox, Herpes Zoster, Herpes Simplex, Measles, Mumps, Rubella

(b) After Active Immunisation

- (i) Either plasma from individuals who have completed a course of active immunisation against tetanus within the previous 21-28 days, or plasma which has been shown by a screening method to contain an adequate titre of tetanus antibody.
- (ii) Plasma from individuals 4-12 weeks after the last (third) injection of a primary immunisation course or 3-12 weeks after a re-inforcing dose of vaccine against rabies. Categories of individuals eligible for immunisation against rabies are given in Health Circular (HC(77) 29, para 1, August 1977.

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- (iii) Plasma taken from individuals within a month of completing a primary immunisation course, or of a re-inforcing dose of vaccine against hepatitis B, or plasma which has been shown by a screening method to have at least 15 i.u./ml (10 i.u./ml in Scotland) of antibody to HB_sAg.

In each case, plasma meeting the required standard will be separated from the red cells, immediately labelled appropriately, frozen and sent to the Blood Products Laboratory. The Red cells may be used for transfusion provided the interval since immunisation accords with the recommendations given in Section II (i) above.

3. Tropical Diseases

Donors should be asked if they have visited places abroad (other than in Western Europe or North America) or have lived in such places within the past five years. The most important diseases to bear in mind when considering the fitness of such donors are malaria and hepatitis B because of their world-wide distribution; certain other diseases must also be considered before accepting, deferring or rejecting such donors.

The following notes give general guidance regarding the fitness as donors of people who have had certain tropical diseases or who have recently returned to the U.K. from the tropics.

- (a) HEPATITIS B. Although hepatitis B is not strictly a 'tropical' disease, its causative virus is far more prevalent in tropical and subtropical areas than in the UK. Donors who have been in such areas must therefore be regarded as being at increased risk of carrying and perhaps transmitting this disease for up to six months after return to or arrival in the U.K.
- (b) MALARIA. The decision whether or not to accept donations from people who have visited or lived in endemic malarious areas (see list and map) may depend on the availability of specific laboratory tests.

If specific tests not available:

Donors who have had ¹ malaria	Defer at least six months from last attack, then accept for plasma fractions ² only.
Donors ¹ born in, formerly resident of or visited endemic malarious areas	Defer until six months elapsed since arrival in/return to U.K.
- six months to five years after arrival in/return to U.K.	Accept for plasma fractions ² only
- more than five years since arrival in/return to U.K. and have remained well:	Accept for normal use.

- NOTES: 1. If a history of malaria is uncertain, use donations for plasma fraction only.
2. Donations for plasma fractions only cannot be used for fresh, fresh frozen plasma, or cryoprecipitate.

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If malaria-specific tests are available:

Donors who have had ¹ malaria more than six months before	Test positive or negative	Accept for plasma fractions ² only
Donors ¹ born in, formerly resident of, or who have visited endemic malarious areas		Defer until six months have elapsed since arrival in/return to UK
- after six months of arrival/in return to UK and have remained well	(Test positive or equivocal) ((Test negative	Accept for plasma fractions ² only Accept for normal use

AMERICAN TRYPANOSOMIASIS (Chagas' Disease)

Because trypanosomiasis may lead to an acute or chronic incurable and even fatal illness - Chagas' disease, blood of persons who have visited or lived in S. America or other endemic areas for this disease should ONLY be used for preparing plasma fractions (not fresh/fresh frozen plasma, or cryoprecipitate). Donations from such people may be used for normal purposes provided they have been shown by suitable tests to be free of antibodies to Trypanosoma Cruzii.

- (d) ARTHROPOD-BORNE ENCEPHALITIDES)
 DENGUE FEVER)
 RIFT VALLEY FEVER)
 SANDFLY FEVER)
 SCHISTOSMIASIS)
 WEST NILE VIRUS FEVER)
 YELLOW FEVER)
- Donations acceptable provided donor completely recovered

RELAPSING FEVER

People may be accepted as donors two years after recovery from this disease.

- (f) AMOEBIC DYSENTRY

Donations acceptable provided adequate treatment has been given.

- (g) PYREXIA OF UNKNOWN ORIGIN IN PERSONS WHO HAVE VISITED THE TROPICS

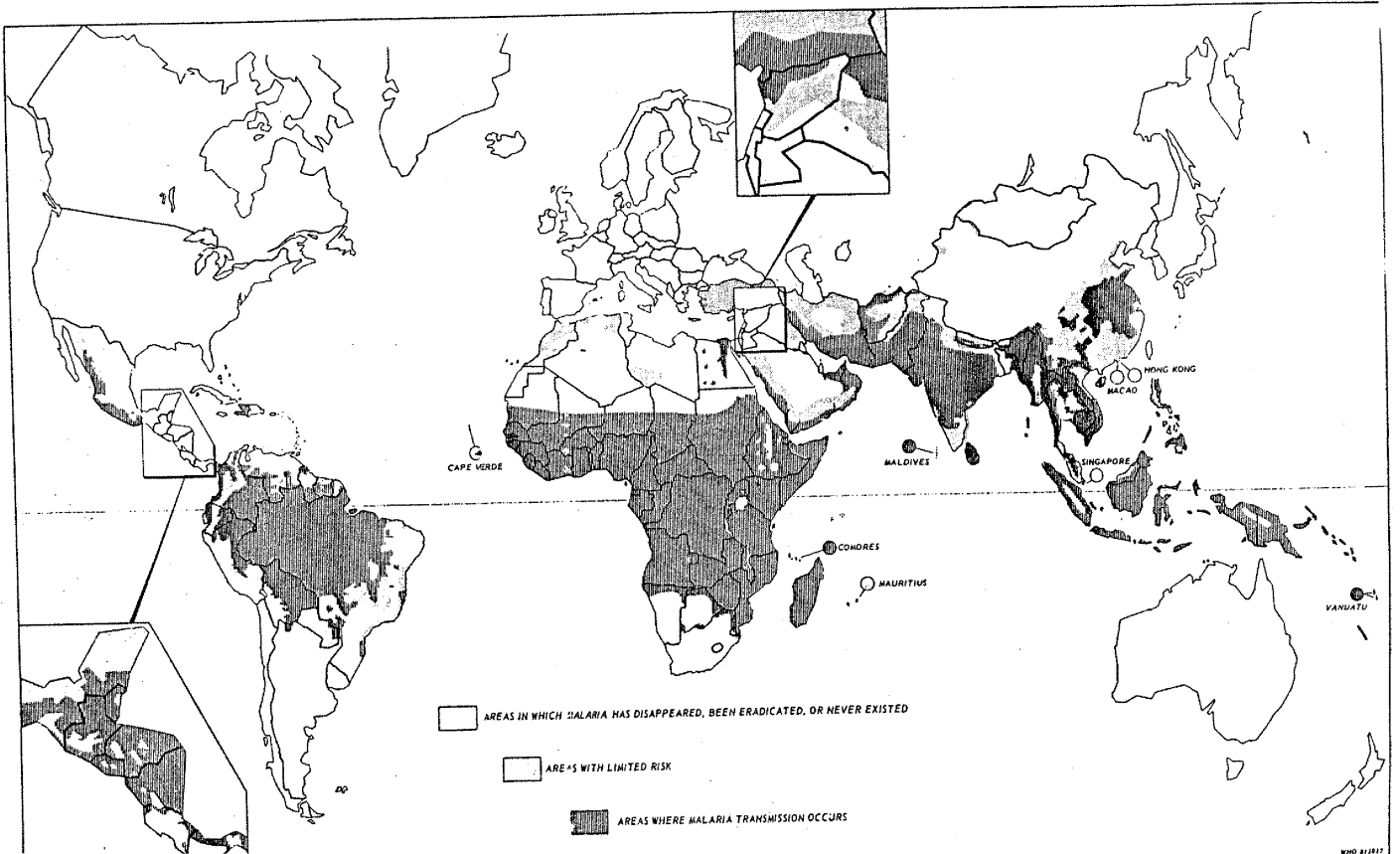
The possibility has to be kept in mind that pyrexias might result from infection with the causative agent of LASSA FEVER or other dangerous viruses. In view of this, blood or blood products from such persons should not be used until three months have elapsed following resolution of the pyrexia, or six months after return to the UK, whichever is the longer.

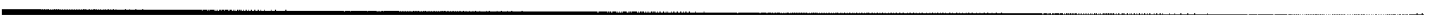
- (h) FILARIASIS)
 KALA AZAR)
 LEPTOSPIROSIS)
 Q FEVER)
 YAWS)
- Donations should NOT be accepted

15.

GENERAL

People returning from tropical areas should not donate blood until six months after arriving in the UK. Many of the diseases above for example, may take the form of a short-lived viraemia, without specific clinical symptoms. People harbouring any of these viruses will automatically be excluded during the potentially dangerous period by adopting this six month period of "quarantine". (See also NBTS 110A attached).





LIST OF ENDEMIC MALARIOUS AREAS

Afghanistan	Guatemala	Paraguay
Algeria	Guinea	Peru
Angola	Guinea-Bissau	Philippines
Argentina	Guyana	Qatar
Bahrain	Haiti	Rwanda
Bangladesh	Honduras	Sao Tome and Principe
Belize	India	Saudi Arabia
Benin	Indonesia	Senegal
Bhutan	Iran	Sierra Leone
Bolivia	Iraq	Solomon Islands
Botswana	Ivory Coast	Somalia
Brazil	Jordan	South Africa
Burma	Kenya	Sri Lanka
Burundi	Korea Republic of (South)	Sudan
Cameroon	Lao People's Democratic Republic	Surinam
Cape Verde		Swaziland
Central African Republic	Liberia	Syrian Arab Republic
Chad	Libyan Arab Jamahiriya	Tanzania, United Republic of
China, People's Republic of	Madagascar	Thailand
Colombia	Malawi	Togo
Comoros	Malaysia	Tunisia
Congo	Maldives	Turkey
Costa Rica	Mali	Uganda
Democratic Kampuchea	Mauritania	United Arab Emirates
Djibouti	Mauritius	Upper Volta
Dominican Republic	Mexico	Vanuatu (formerly New Hebrides)
East Timor	Morocco	Venezuela
Ecuador	Mozambique	Vietnam
Egypt	Namibia	Yemen
El Salvador	Nepal	Yemen, Democratic
Equatorial Guinea	Nicaragua	Zaire
Ethiopia	Niger	Zambia
French Guiana	Nigeria	Zimbabwe
Gabon	Oman	
Gambia	Pakistan	
Ghana	Panama	
	Papua New Guinea	

List based on information from Ross Institute of Tropical Hygiene, 1982

