ITEM 6 OF 25.2.88

0032

REPORT FOR THE NATIONAL MEDICAL DIRECTOR AND THE REGIONAL DIRECTORS OF THE SNBTS ON DONOR SELECTION CRITERIA.

Background:

The Guidelines on the Care and Selection of Blood Donors issued by the NBTS have been felt in the SNBTS to require adaptation. The National Medical Director and the Regional Directors therefore asked me to prepare a report comparing donor selection practices in the five Scottish regions, in an attempt to assess the significance of the existing differences in practice between the SNBTS Centres and the NBTS Guidelines.

Method:

By comparing our present selection criteria in the SEBTS, which are codified by "diagnosis" and are kept up-to-date, with the NBTS document, I identified a list of conditions where differences of interpretation existed, and others where no difference existed but which might prove contentious in other Centres. I then arranged with the RTD's to discuss these issues with the most appropriate personnel in each Centre, and to ask their views on the NBTS document.

Results:

There was general agreement that the NBTS Guidelines were unsatisfactory in format. The information was felt to be badly presented, and in particular there was unanimous criticism of the system of lists and "sub-lists" of conditions.

In addition to this, every Centre criticised particular items in the NBTS Guidelines, though there was no uniformity of topic criticised. Listed below are the most obvious areas of disagreement, in no particular order.

Frequency of call-up. All Centres used a 6 month call-up interval except Glasgow, who routinely call some donors 3 monthly. Other Centres, eg. Edinburgh, occasionally call 'O' negative donors at 3-4 months.

Anaemia. All Centres are using the same criteria for Hb as the NBTS, though procedures differ widely. Dr. Brookes made a plea for a computer system which allows previous failed Hb tests to be "flagged".

Medication. No Centre saw this as a major problem. Most are content to decide on the eligibility of a donor taking medicines on an ad hoc basis, and all would take a conservative view on the grounds that where doubt exists, donor and patient safety are best served by deferral. Dr. Whitrow pointed out that section ix, pS, of the NBTS Guidelines is difficult to enforce because of the frequency of use of non-steroidal anti-flammatory drugs and tranquillisers/anti-depressants, and he would like to see a liberal interpretation applied to these categories.

Allergy. There is general agreement with the NBTS Guidelines, but Dundee never accepts asthmatics, however mild.

Diabetes. Again Dundee is at odds with the other regions in accepting donors on oral hypoglycaemic agents. All other Centres are in line with NBTS Guidelines (accept donors on diet alone).

Epilepsy. Inverness are in line with the NBTS Guidelines (accept after 2 years fit-free, with discretion), but the other Centres prefer never to accept these donors.

Infectious mononucleosis. Edinburgh and Inverness defer for 1 year after Glandular Fever, the other Centres being in line with NBTS (2 years).

Cancer. Edinburgh accepts a history of cured skin cancer (eg. basal cell); all others defer all cancer patients permanently. The NBTS Guidelines do not address the question of donors with a history of cancer in situ cured by surgery, for example carcinoma of cervix.

My opinion is that this is a special case, analogous to skin cancer and different in its implications from other early cancers such as breast cancer treated by lumpectomy or bowel cancer treated by endoscopic removal. In these latter cases the patients would usually be under long-term follow-up and will have been identified as a result of having symptoms rather than having been screened for the presence of disease. This is obviously a difficult area and would require careful thought in drawing up any Guidelines.

Malaria. Edinburgh is the Centre diverging most widely from the NBTS Guidelines, which are generally seen to be satisfactory. The Edinburgh criteria at present make no provision for allowing former residents or long-term visitors to an endemic zone to become normal donors at any time in the future. In Edinburgh an "incubation period" of 3 months is used at present, after which short-term visitors are accepted for normal use if they have remained well and have taken anti-malarial tablets for 4 weeks after return. These criteria are under review at present, and I anticipate that criteria more in line with the current NBTS proposals will be adopted soon.

Thyroid disease. This topic causes general confusion. Edinburgh accepts a past history of thyroid disease if at present euthyroid, even on replacement therapy. Glasgow takes for biochemical serum. Dundee would be happy to accept on stable therpy, but Dr. Brookes is unhappy about accepting donors who have had I^{131} treatment. Inverness and Aberdeen defer all donors with thyroid disease, though Aberdeen may accept in some circumstances.

Hypertension. Edinburgh alone accepts donors with hypertension on diuretics (provided BP normal).

Gastrectomy. Glasgow, Edinburgh and Inverness will accept if Hb normal (NBTS - permanent deferral).

Dental treatment/GA. It was generally felt that it was excessively cautious to wait 1 month after a GA for minor dental surgery, as recommended by NBTS.

Tattooing. Glasgow would like to see a more liberal view taken, in view of the fact that most tattoo/ear-piercing salons are now accredited to use sterile techniques. At present they use the same criteria as other Centres, namely that donors should be deferred for six months after any tattooing, but this is perceived as a significant and unnecessary source of deferrals. All other Centres use a six month deferral period.

Conclusions:

No doubt minor differences exist other than those discussed above, but it can be seen that major differences of opinion are few. Many of the differences relate to local factors, eg. the call-up interval in Glasgow, and any Guidelines could readily be designed to accommodate such differences where no scientific principles are thought to be at issue. Other differences reflect the degree of conservatism or otherwise with which known facts are interpreted, eg. gastrectomy or the interval after Glandular Fever. Finally, and most difficult, is the groups of disorders where a compromise between the ideal and the practical is necessary. The most obvious example of this is malaria, a problem which becomes more acute as more people travel to endemic zones. My own view of this is that the NBTS Guidelines are satisfactory, and that agreement on this would not be difficult to obtain.

I formed the impression that all Centres were willing to attempt to reach a concensus. The evidence obtained suggests that this would be relatively easy to achieve. While the information in any such document could be based on the NBTS Guidelines with amendments derived from the above data, it would be important to strive for a clear and practical way of presenting the data.

Recommendations:

1. The NBTS Guidelines should not be adopted by the SNBTS in their present form.

2. If the SNBTS Directors are unanimously in agreement, a comprehensive set of selection criteria based on the present Edinburgh Handbook and taking account of the various points that have been raised during this survey should be prepared in draft form for discussion. I feel that the differences between the Centres are small enough for this to be undertaken by one person, rather than by a working party or committee. Any such document would naturally have to be flexible enough to take account of local factors, and also be designed in a way which allows easy updating.

J. Gillon,
11.11.85.

JG/DS