Ø038

MSBT 4/4

CONFIDENTIAL TO COMMITTEE MEMBERS

NOT FOR PUBLICATION

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

MINUTES OF THE FOURTH MEETING HELD ON 15 DECEMBER 1994 IN ROOM 310 EILEEN HOUSE

Chairman: Dr J S Metters

Members: Dr A Cant
Dr D W Gorst

Dr R Mitchell
Dr P Mortimer
Dr R J Perry
Dr A Robinson
Dr T Snape
Dr R E W Warren
Professor J D Williams
Professor A Zuckerman

Observers: Dr A Keel
Dr G Mock
Dr I H Nicholas
Mr P Pudlo
Mr R M T Scofield
Mrs G Silvester
Mr J S Sloggem
Ms S A Wellsteed

Secretariat: Dr A Rejman
Mr T Kelly
Mr D Burrage
Ms M Sandillon

Note: CMO was present for item 7 (part)

1. Chairman's Introduction

The Chairman welcomed Ms Sally Wellsteed (DH Health Promotion (Medical) Division with responsibility for communicable disease policy including HIV/AIDS), present for item 5 and Mrs Glenda Sylvester, Medicines Control Agency present for items 5 and 6.

2. Apologies for absence

Apologies for absence were received from Miss Lord, Mr McMaster, Dr George and Dr Purves, for whom Mr Sloggem deputised.

3. Minutes of the third MSBT meeting - 29 September 1994 (paper MSBT 3/12).

The Chairman apologised on behalf of the secretariat for the very late circulation of the minutes of the third meeting, which would be endorsed at the next meeting. Dr Mitchell asked that "the only option" should be amended to read "one option" in paragraph 9.1 on page 7 of the draft minutes. It was agreed that the minutes should reflect that one option was to give surplus products to developing countries but that this would pose difficulties.

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

- minute 4.1: combined HIV and HTLV test

4.1 Dr Robinson said that a paper reporting on the trial of the Launch Biokit HIV1 and 2 and HTLV 1 and 2 antibody assay at Leeds RTC had been accepted for publication. It was agreed that the pre publication final draft paper should be circulated to members for their comments. The current recommendation not to introduce the combined test would need to be considered in the light of the report.

ACTION - DR Robinson, Secretariat.

- minute 4.2: guidelines for reporting the transmission of microbiological agents by blood

4.2 Dr Mitchell said that a report would be prepared for the next meeting on how a better definition of what should be reported could be achieved. Information had been received from Canada but not from CDSC, which Dr Mortimer agreed to pursue.

ACTION - Dr Mitchell, Dr Mortimer.

- minute 4.5: tissue banks

4.3 Mr Pudlo said that the report of the study's findings was almost complete and would be submitted to DH before the end of December 1994. It would be for DH to decide whether the report, which covered legal and ethical aspects should be made public. Mr Pudlo informed the Committee in confidence that the study had found possible inconsistencies between the Human Tissue Act and practice. People other than registered medical practitioners were engaged in recovery of tissue from mortuaries. Also it had not been possible to confirm in every

case that consent had been obtained for the purpose for which the tissue was to be used. However, there would be difficulties in maintaining the ethical principles of non-commerciality when tissue banks were trying to recover legitimate costs.

In general the study had found a lack of any strategic approach to tissue banking. There was a case for standardisation without being prescriptive against the freedom and flexibility needed for tissue banking to develop in a scientific way.

ACTION - Mr Pudlo

- minute 7.5: promoting the safety of transplantation of human tissues and organs

4.4 The Chairman thanked Members for their comments on the paper and reported that there had also been extensive internal consultation. The paper would be submitted to Ministers seeking approval for consultation with the professions, who would be asked whether the paper was a suitable document to be issued as guidance to the NHS.

ACTION - Secretariat

- minute 9.6: ALT testing of blood donations

4.5 The Chairman said that agreement on a common UK position was needed before recommendations on ALT testing of blood donations could be made to Ministers. Mr Kelly reported that he was pursuing this with administrative colleagues in SHHD, WO and DHSS NI.

ACTION - Secretariat

- minute 10.2: Quarantining of FFP for clinical use

4.6 Dr Robinson reported that there were a number of issues which SACTTI would need to consider before it was in a position to put forward its detailed proposals.

5. HIV 0 (paper MSBT 4/1).

5.1 The Chairman said that HIV 0 had been discussed the previous week at EAGA, whose concern was that in this country we should be trying to ensure that tests were picking up HIV 0. However, samples were not available as the French would not release sera. Dr Mortimer said that he had confidence in the quality of the results obtained by colleagues in France. An offer had been made by a commercial company with an interest in providing sera, but the source of the sera was unknown.

5.2 Dr Rejman thanked MCA and MDA colleagues for providing papers appended to MSBT4/1 and rererred to the recommendations of the WHO reported in Press Release WHO/50 which corresponded with the view taken by MSBT at the last meeting. The Committee had agreed that while HIV 0 did not represent a significant risk to the blood supply in the UK and did not justify any change to present arrangements, it should be kept under close review.

5.2 The Committee noted that on 9 November the French had announced withdrawal of 4 kits from the French market, and a 5th kit, Wellcozyme Recombinant (Murex) had been withdrawn from screening use and could only be used for supplementary testing and for differentiation of HIV1 from HIV2. Dr Rejman reported that two RTCs use an HIV1/2 ELISA from Ortho Diagnostic Systems, and that it had been confirmed that the Wellcozyme HIV Recombinant (Murex) test withdrawn by the French is the monospecific HIV 1 test and is not used by the UK blood transfusion services as a screening test.

5.3 The risk of HIV 0 in a UK donor was considered to be very small. Very few UK residents came from the Cameroon or Gabon and may in any case be excluded by the HIV/AIDS criteria or the one year malaria exclusion. Changing from one test system to another carried risks to the blood supply of administrative or technical error.

5.4 Dr Robinson said that exclusion of all those who came from Cameroon or Gabon was not an option as it would be discriminatory.

5.6 The Chairman said that while there was a low risk of an HIV 0 positive donor in the system, the possibility could not be excluded and Members would be kept informed about the position on availability of HIV 0 positive sera.

5.7 Dr Rejman reported that the NBA had informed DH that none of the kits taken off the German market after failing inspection by the Paul Ehrlich Institute are currently being used in the blood transfusion service, although some might be used in hospital laboratories.

5.8 Ms Wellsteed said that the system for passing information to laboratories in this country should be improved. Dr Snape said that BPL was aware two weeks before the Paul Ehrlich Institute withdrawal that Behringwerke had recalled a kit, and asked whether there was a mechanism which acted as a clearing house for product defects to be handled. The Chairman said that the MDA gives bulletins when defects in equipment are identified. Mrs Sylvester proposed a meeting between MCA, MDA and Dr Rejman to discuss improvements in the reporting system.

ACTION - MCA, MDA, Secretariat

5.9 It was pointed out that the remit of the Committee went beyond recipients; some donors would be tested with these kits for organ transplantation. PHLS comparison with German test results on these kits did not entirely concur - there were differences in sensitivity of batches for low affinity antibody. Dr Mortimer said that he had written to Dr Rejman about the need for PHLS to build up a larger panel of seroconversion material at Colindale. Dr Mortimer considered it anomalous that 2 EC counties with stringent licensing arrangements could take precipitate action to withdraw kits.

5.10 The Chairman said that the lack of a formal licensing system for diagnostic kits was a temporary phenomenon and the in vitro diagnostic directive would introduce regulation in 1997. The Committee was concerned at the lack of suitable mechanisms to identify suspect kits and thought that MDA should consider with MCA a system of safety action notes for test kits. On panels of sera for evaluation, the Committee was concerned that all kits should be properly evaluated, but the method must be for PHLS and the National Blood Authority to determine.

6. EC activities relevant to the Committee

6.1 Mrs Sylvester said that a list of activities had been submitted to the Committee at its last meeting. The main progress was on notice to applicants and information on source materials; the outcome of consideration by CPMP was not yet known.

7. HCV look back (papers MSBT 4.2 and MSBT 4.3)

7.1 The Chairman thanked Professor Zuckerman, Dr Robinson and Dr Gorst for drawing up the sub committee's report following the discussion at the last meeting. Dr Robinson introduced the report (paper MSBT 4.3) and summarised the comments expressed at the last meeting on the SACTTI presentation on the merits of introducing HCV look back.

7.2 Dr Robinson reported that since the last meeting, interferon had very recently been licensed for the treatment of hepatitis C virus chronic liver damage. Despite the reservations which had been expressed at the last meeting, the sub committee's view was that there was a duty of care towards the patients who were affected, and the implicated donors. The best estimate was that 3,000 recipients were at risk of contracting transfusion transmitted HCV liver disease. It was now estimated that 60-80% of recipients who developed transfusion transmitted HCV infection would become carriers and that 50% would develop chronic hepatitis. Some patients could be viraemic despite normal liver enzyme levels. 20% of infected recipients may develop cirrhosis.

7.3 Dr Robinson said that given the time span of events

transfusion transmitted hepatitis C could have serious implications for the transfusion population. The overriding view of members who commented to the subcommittee, and the view of the sub committee was that transfusion recipients, some of whom may have been harmed, would benefit from a lookback exercise. Liaison with hepatologists would be needed to ensure a consistent and harmonised approach across the UK, and the legal and ethical implications would need to be carefully considered.

7.4 The Chairman said that the sub committee's report recognised a duty of care towards recipients and implicated donors, and that if the full committee agreed, it would need to consider the consequences of the duty of care. Lawyers would look to the committee for a view on how to carry out the duty of care. The process should aim to do what is reasonable and it was not obligatory to go beyond that. This would include the cost of identifying recipients against the numbers who would benefit from eg currently available treatment, or treatment likely to be available in the future, and the issue of the right to know, or the right not to know.

7.5 Dr Perry said that recognition of the duty of care was the right decision, and that the Committee's position needed to be clear on what had changed since 1991 to allow look back now. Dr Robinson said that it was only more recently that the seriousness of hepatitis C had been recognised. The Chairman said that in 1993 special arrangements had been made to inform recipients of human growth hormone and pituitary gonadotrophins that they were at risk of contracting CJD despite the absence of any preventative treatment, whereas in the case of HCV patients there would be benefit from treatment which was becoming available, as well as counselling.

7.6 Dr Robinson said that 4 writs had been issued against the NBA and its legal advice was that the duty of care existed in this case. Donor anonymity needed to be maintained. Commenting on the right to know issue, Dr Robinson reminded the Committee that France and Ireland had invited its transfusion recipients to come forward for testing if transfused before the last 5 years.

7.7 Dr Warren said while there was a need to take action, it was difficult to undertake cost benefit analysis when the health gains 5 years ahead were not known. Professor Zuckerman said that new anti-viral drugs had been introduced recently and that significant developments in anti-viral therapy were possible over the next five years. In this case there were 6 different genotypes and some would respond. Cost benefit analysis was very important as major expenditure was involved, but the health economics were not for scientists to decide. Professor Zuckerman shared the view expressed by Dr Mortimer that the question of lookback was driven by lawyers. It was important to distinguish between those infected with HCV through NHS treatment and by other means.

7.8 Members said there were practical problems in testing large numbers of samples, and asked whether duty of care might not be satisfied if archive samples were not tested to catch those donors who did not donate after 1991, or if there was no sample from a donor who gave in the 1980's, whether the donor should be traced and asked for a sample. Professor Williams said that the practical problems associated with look back should not interfere with taking the right decision, which was that look back was necessary.

7.9 The Chairman said that it was not possible to cover all the detail at this meeting and suggested that a sub group should draw up guidelines. Professor Zuckerman said that the involvement of hepatologists was crucial, and that guidelines should not attempt to prescribe a course of treatment to clinicians. The Chairman said that a flowchart of options and non prescriptive guidelines for either consultant or GP were needed. It was for this committee to decide on the principles of look back and on whether it was reasonable on cost grounds to test for certain genotypes, but issues related to funding of treatment and the way in which fundholders decided to spend their resources were outside its remit.

7.10 CMO said that in the public interest an urgent decision on a UK wide basis was needed on the matters of principle. The detail was important, but less urgent.

7.10 Dr Keel said that the view in Scotland was that the Secretary of State was vulnerable as look back was feasible since donors could be identified and traced, and advice from Scottish Office lawyers was that look back should start immediately. The Chairman stressed the need for maintaining uniformity in the UK, but said that it was for the Secretaries of State, not the Committee to decide on whether Scotland should go ahead early.

7.11 Dr Snape and Dr Gorst raised the question of fractionated blood products and haemophilia patients who may have been infected with HCV prior to the introduction of heat treatment in 1985. The Chairman said that in Ministers' view this group and the transfusion recipients infected prior to 1991 had received the best available treatment in the light of medical knowledge at the time, and that Ministers were not minded to accede to ex gratia payments for either group.

7.12 Following the discussion the Committee agreed its advice to Ministers as:

i. in the Committee's view there is a duty of care towards those infected with HCV as a result of NHS treatment. It follows that procedures should be put in place to identify those patients at risk;

ii. whatever is done should be done equally and uniformly throughout the UK;

iii. guidance should be drawn up as soon as possible:

a) on procedures for identifying those at risk, and

b) while it was for the medical practitioner responsible for each patient identified as at risk to decide what should be made known to the patient about his/her risk status, and to decide whether and what treatment should be advised, guidance on the counselling and treatment options would be desirable.

7.13 The Committee agreed that these conclusions would be passed on to the Secretaries of State of all four Health Departments. If Ministers wished, an ad hoc Working Party could be established drawn from the membership of the Committee, and the advisory Group on Hepatitis.

7.14 The Chairman reminded Members that they provide confidential advice to Ministers, and that any enquiries about the Committee's conclusions or its work should be referred to the Departmental Press Officers.

ACTION - Secretariat

8. Any other business

8.1 Dr Robinson reported that the Advisory Committee on Donor Selection was revising the AIDS leaflet for donors to issue to donor sessions in July. The secretariat would circulate the draft leaflet for Members for comment direct to Dr Robinson.

ACTION - Dr Robinson, Secretariat

8.2 Dr Snape said that there had been a series of recalls of CJD implicated blood and plasma products by other regulatory authorities. There was no evidence of CJD transmission through blood or plasma products. No case was made for any change in UK procedure for donor selection and BPL would continue to liaise with MCA. The Committee noted that in France any history of dementia resulted in donor exclusion.

9. Date of next meeting

9.1 The Chairman wished Members a happy Christmas and new year and it was agreed that the next meeting would be arranged for late February/early March.