Risk Communication Gaps in Notification

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Is vCJD transmitted by blood? Yes

Possible transmission of variant Creutzfeldt-Jakob disease by blood transfusion

THE LANCET • Vol 363 • February 7, 2004

C A Llewelyn, P E Hewitt, R S G Knight, K Amar, S Cousens, J Mackenzie, R G Will

Interpretation Our findings raise the possibility that this infection was transfusion transmitted. Infection in the recipient could have been due to past dietary exposure to the BSE agent. However, the age of the patient was well beyond that of most vCJD cases, and the chance of observing a case of vCJD in a recipient in the absence of transfusion transmitted infection is about 1 in 15 000 to 1 in 30 000.

Lancet 2004; **363:** 417–21

Preclinical vCJD after blood transfusion in a *PRNP* codon 129 heterozygous patient

www.thelancet.com Vol 364 August 7, 2004

Alexander H Peden, Mark W Head, Diane L Ritchie, Jeanne E Bell, James W Ironside

We report a case of preclinical variant Creutzfeldt-Jakob disease (vCJD) in a patient who died from a non-neurological disorder 5 years after receiving a blood transfusion from a donor who subsequently developed vCJD. Protease-resistant prion protein (PrP^{res}) was detected by western blot, paraffin-embedded tissue blot, and immunohistochemistry in the spleen, but not in the brain. Immunohistochemistry for prion protein was also positive in a cervical lymph node. The patient was a heterozygote at codon 129 of *PRNP*, suggesting that susceptibility to vCJD infection is not confined to the methionine homozygous *PRNP* genotype. These findings have major implications for future estimates and surveillance of vCJD in the UK.

vCJD in United Kingdom

7 Sept 2004 - BPL (England) & PFC (Scotland) identified specific batches where donor later developed vCJD

- 16 batches FVIII
- 8 batches FIX
- 77 batches FVIII-excipient (albumin)
- Anti-thrombin
- IGIV
- Cryopaste (The Netherlands)
- Contract Fractionation (Belgium)

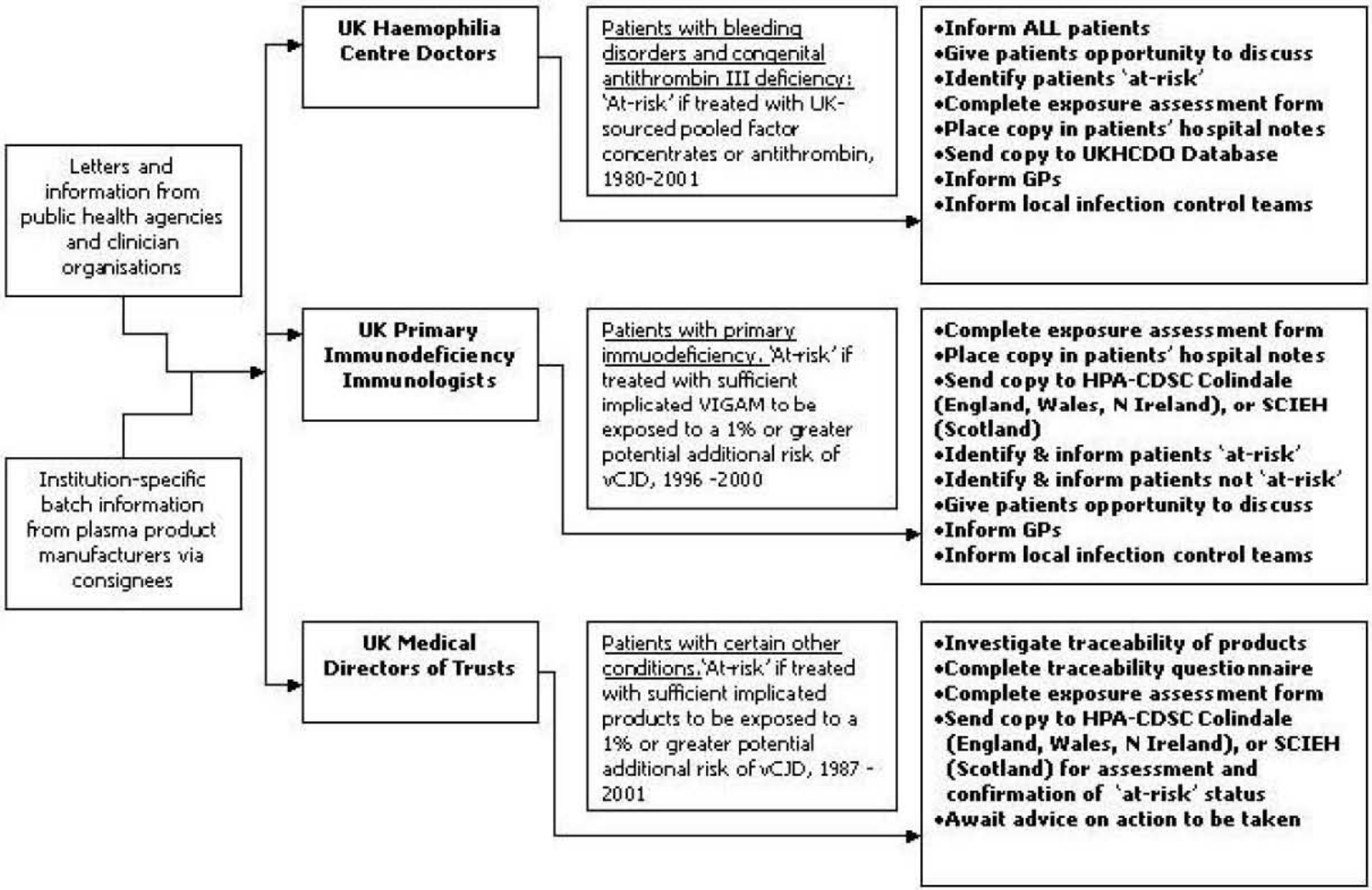
vCJD Risk for Recipients of UK Plasma Products

UK Hemophilia Treatment Centres Notified of Conclusion of the UK Risk Assessment on

9 Sept 2004 (Press Embargoed until 20th)

"All patients with bleeding disorders…who have received clotting factors derived from UK-sourced plasma between 1980-2001 should be considered at risk for vCJD for public health purposes."

7th SEPTEMBER 2004
vCJD AND PLASMA PRODUCTS:
SUMMARY OF PATIENT NOTIFICATION EXERCISE*



* The Health Protection Agency's Communicable Disease Surveillance Centre (Colindale) is handling this notification in England, Wales and Northern Ireland.
The Scottish Centre for Infection and Environmental Health is handling this notification in Scotland.

Implications for recipients outside of UK

- 9 Sept 04 - UK HTC Directors notified (Press embargoed)
- WFH received notification
- 21 Sept 04 – UK Press Conference
- UK manufacturers (BPL & PFC) declined to provide destinations of exported products
- Reports received from WFH national organizations and individual patients
- 22 Sept 04 - US FXI patient contacted WFH
- FDA alerted
- 28 Sept 04 - NHF MASAC Advisory # 401

vCJD in France

- 8th case of vCJD in France – 21 Oct 2004
- Donors plasma was collected by LFB and later acquired by Centeon as cryopaste
- Used for the production of one lot of clotting factor manufactured by Centeon in 1996 and sold only in Italy and Germany, recalled in 1997 due to record policies
- ZLB Behring initiated a look-back.
- Never notified by LFB directly or through the distribution chain
- Informed the patient, regulatory and medical communities – 13 Jan 2005

Implicated Fractionation

- BPL (England)
- LFB (France)
- PFC (Scotland)
- Sanquin (The Netherlands)
- Belgium – Contract Fractionation LFB
- Centeon (ZLB Behring predecessor)

Implicated Products

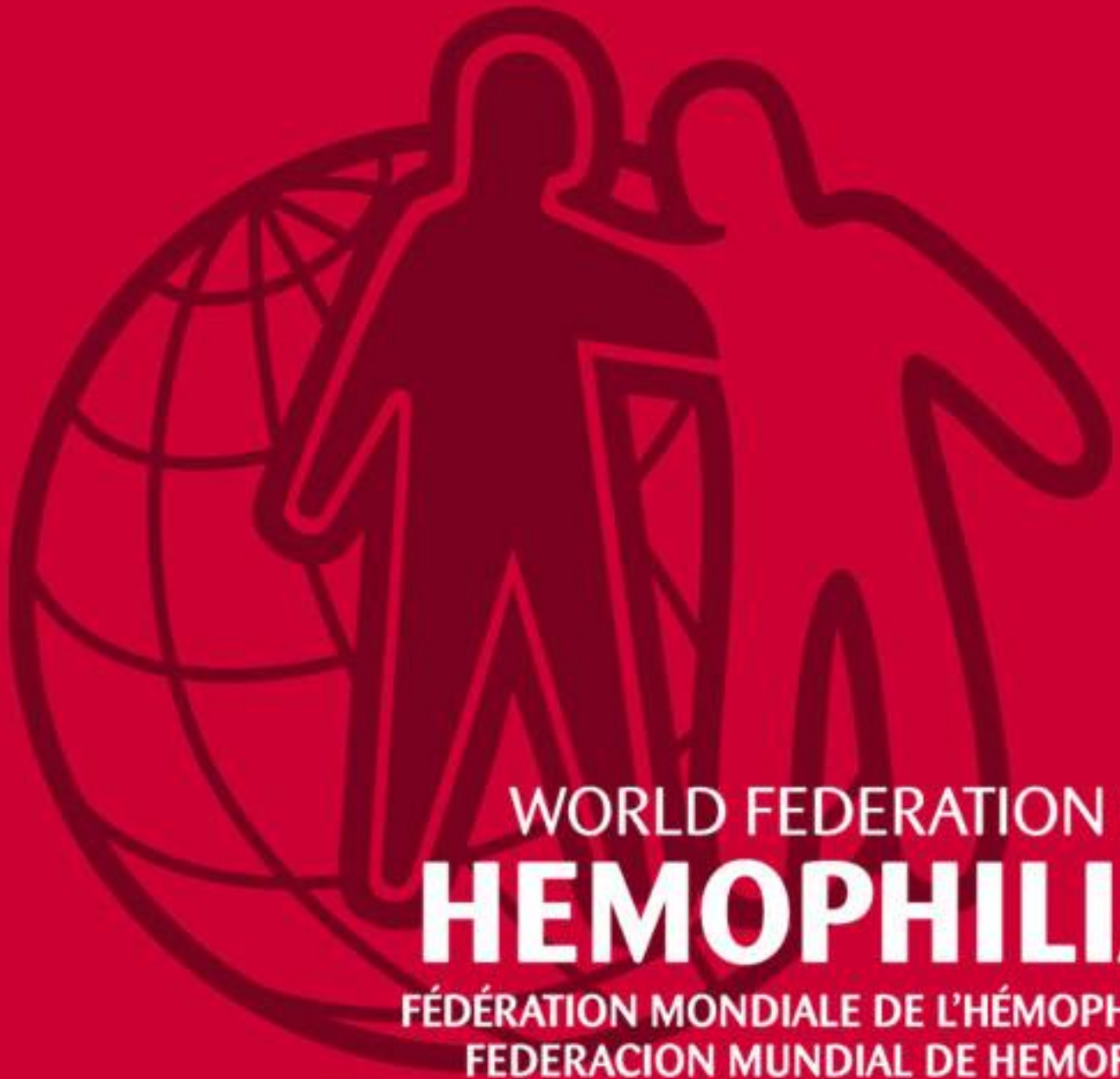
- Albumin
- Anti-Thrombin
- Factor VIII
- Factor IX
- Factor XI
- Fibrinogen
- Intramuscular Immune Globulin
- IVIG

Communication Gaps
Final Thoughts

- Migration of product and plasma occurs
- Recipients of exported blood products received little or no information following the UK patient notification creating a gap in the communication chain
- The lack of comprehensive global notification requirements from Donor Plasma → Intermediate → Manufacture → Patient creates a gap in the communication chain (e.g. Centeon)

Communication Gaps
Final Thoughts

- Patient right to be informed
- Balance overreaction and patient stigmatization vs. under reaction and lack of transparency
- Foreigners and nationals treated equally
- Counseling and competent explanation essential to notification process
- Potential long-term US concern for patients with rare bleeding disorders dependent upon non-US products



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