Patient Safety Alert

Veterans Health Administration Warning System
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AL10-14 July 7, 2010

Item: **Hepatitis C virus (HCV) testing using Novartis Chiron RIBA HCV 3.0 Strip Immunoblot Assay (SIA) reagents**

Specific Incident: A VA Medical Center was informed by an independent reference laboratory that a reagent used during testing of Veteran patient samples was voluntarily recalled by the manufacturer. Novartis Vaccines and Diagnostics, Inc. (Novartis) initiated by letter, a voluntary market withdrawal of specific lots of its Chiron RIBA HCV 3.0 SIA reagents. Refer to Attachment 1 for the lot numbers and expiration dates for the affected reagents.

Testing by Novartis supports that an increase in FALSE POSITIVE hepatitis C antibody results is possible with the affected lots. Novartis has no evidence that true positive specimen results are affected.

General Information: The VHA Product Recall Office in the National Center for Patient Safety was made aware of and posted the Novartis voluntary market withdrawal on March 12, 2010, on the VHA Hazardous Recalls/Alerts website. By March 26, 2010, all VHA facilities had closed out this posting and no VHA facilities reported that they had any of the affected reagents at the time of the voluntary market withdrawal.

The possibility exists that testing may have been conducted using the affected reagents in VHA laboratories or independent reference laboratories contracted to conduct hepatitis C antibody testing, dating back to October 15, 2008. There is a remote possibility that patients received unnecessary treatment for hepatitis C based on FALSE POSITIVE hepatitis C RIBA testing. Treatment for hepatitis C should not be based on a positive hepatitis C RIBA test. There is also a possibility that patients received an unnecessary diagnosis of exposure to hepatitis C, based on a FALSE POSITIVE hepatitis C RIBA, which can have insurability consequences in the private sector. We are asking for facilities to review the records of affected patients and take the following actions.

Actions:

1. By Close of Business (COB) July 16, 2010, **the Facility Director (or designee)**, shall ensure the following actions are completed:

    a. Confirm whether the affected reagents were used by your VHA laboratories (including medical centers, CBOCs, and other facilities) for hepatitis C antibody testing of any individuals after October 15, 2008.

    b. Consult with independent reference laboratories used by your VHA laboratories (including medical centers, CBOCs, and other facilities) and determine whether the affected reagents were used for hepatitis C antibody testing of any individuals associated with your facility after October 15, 2008.

    c. Compile a list of **patients** identified by Actions 1a and 1b.

    d. Compile a list of **employees**, academic affiliates, students, contractors, volunteers, other individuals who may have had an occupational exposure to hepatitis C, job applicants who had a pre-placement examination, and any other individuals identified by Actions 1a and 1b.

NOTE: If your facility did not conduct these tests with affected reagents nor send specimens to an independent lab that utilized affected reagents, proceed to Action 4 and close out this Patient Safety Alert.

2. For patients identified in Action 1c: By COB July 30, 2010, **the Hepatitis C Lead Clinician** (**or designee)** (VHA Directive 2007-022) shall ensure the following actions are completed:

    a. For patients who had a negative result on the RIBA: no additional testing is required.

    b. For patients who had a positive antibody result on the RIBA, where the test was conducted using the affected reagents AND a hepatitis C RNA PCR was negative or not performed, follow the additional notification, testing

and documentation guidelines in Attachment 2.

3. For individuals identified in Action 1d: By COB July 30, 2010, **the Designated Occupational Health Physician (or designee)** shall ensure the following actions are completed:

   a. For individuals who had a negative result on the RIBA: no additional testing is required.

   b. For individuals who had a positive antibody result on RIBA, where the test was conducted using the affected reagents, see attachment 3.

4. By COB August 15, 2010, the **Patient Safety Manager** shall document the status of this Patient Safety Alert on the VHA Hazardous Recalls/Alerts website. http://vaww.recalls.ncps.med.va.gov/WebRecalls/Recalls.html

Attachments:

1. Novartis Diagnostics Important Market Withdrawal Notification dated February 26, 2010.

2. Guidance Regarding Patients

3. Guidance Regarding Employees and Other Individuals

References:

1. VHA Directive 2007-022, July 23, 2007 – National Hepatitis C Program http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1586

Source: A VHA facility

Contacts:

Dr. William Triest, National Director, Pathology & Laboratory Medicine Service, VHA Office of Patient Care Services at (304) 429-6741 x2445

Dr. David Ross, Director, Clinical Public Health Programs at (202) 461-1033

Ms. Pamela Hirsch, Clinical Program Manager Occupational Health at (202) 461-1042

Mr. Bryanne Patail or Dr. Danielle Hoover, National Center for Patient Safety (NCPS) at (734) 930-5890

ATTACHMENT 1 - Novartis Diagnostics Important Market Withdrawal Notification

NOVARTIS
DIAGNOSTICS

February 26, 2010

IMPORTANT MARKET WITHDRAWAL NOTIFICATION
Chiron® - RIBA HCV 3.0 SIA
For *In Vitro* Diagnostic Use

Dear Customer,

Novartis Vaccines and Diagnostics, Inc. (Novartis Diagnostics) received complaints from customers reporting false positive assay results when using the *Chiron® RIBA HCV 3.0 SIA (Strip Immunoblot Assay).* Novartis Diagnostics initiated an investigation including a review of all batch records for the lots listed below and determined that all lots were manufactured according to established procedures and met all performance specifications. In addition, the kit lots were retested as part of this investigation and confirmed all lot-release specifications continue to be met. However, as part of the investigational testing performed to date, Novartis Diagnostics reproduced discordant results with specimens returned from customers on certain lots of *Chiron® RIBA HCV 3. 0 SIA.* The etiology of these discordant results is undetermined, and testing evidence supports that an increase in false positive results is possible with the lots referenced in the table below. Internal testing of known positive specimens on retained lots yielded accurate results; therefore, we have no evidence that true positive specimen results are impacted.

The *Chiron® RIBA HCV 3.0 SIA* Instructions for Use (Product Code 930600, Issue Date *12/2007)* performance claim for specificity is 98.8 % (2964 reported negative out of 2999 total presumed negative specimens tested). As the root cause of this issue is undetermined and the potential exists for increased false positive rates, Novartis Diagnostics has initiated a voluntary Market Withdrawal for the affected lots and asks all customers receiving this notification to follow the directions listed at the end this letter.

The table below provides the lots affected by this issue:

Chiron® **RIBA HCV 3.0 SIA**		**Product Code**
Lot Numbers	**Expiration Date**	
YA1209	22 JUN 2009	
YA1691	31 AUO 2009	
YA1758	22 SEP 2009	**930600**
YA1804	29 SEP 2009	
98290	17 MAY 2010	
98743	31 MAY 2010	

ATTACHMENT 1 Continued

NOVARTIS
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Please do the following:

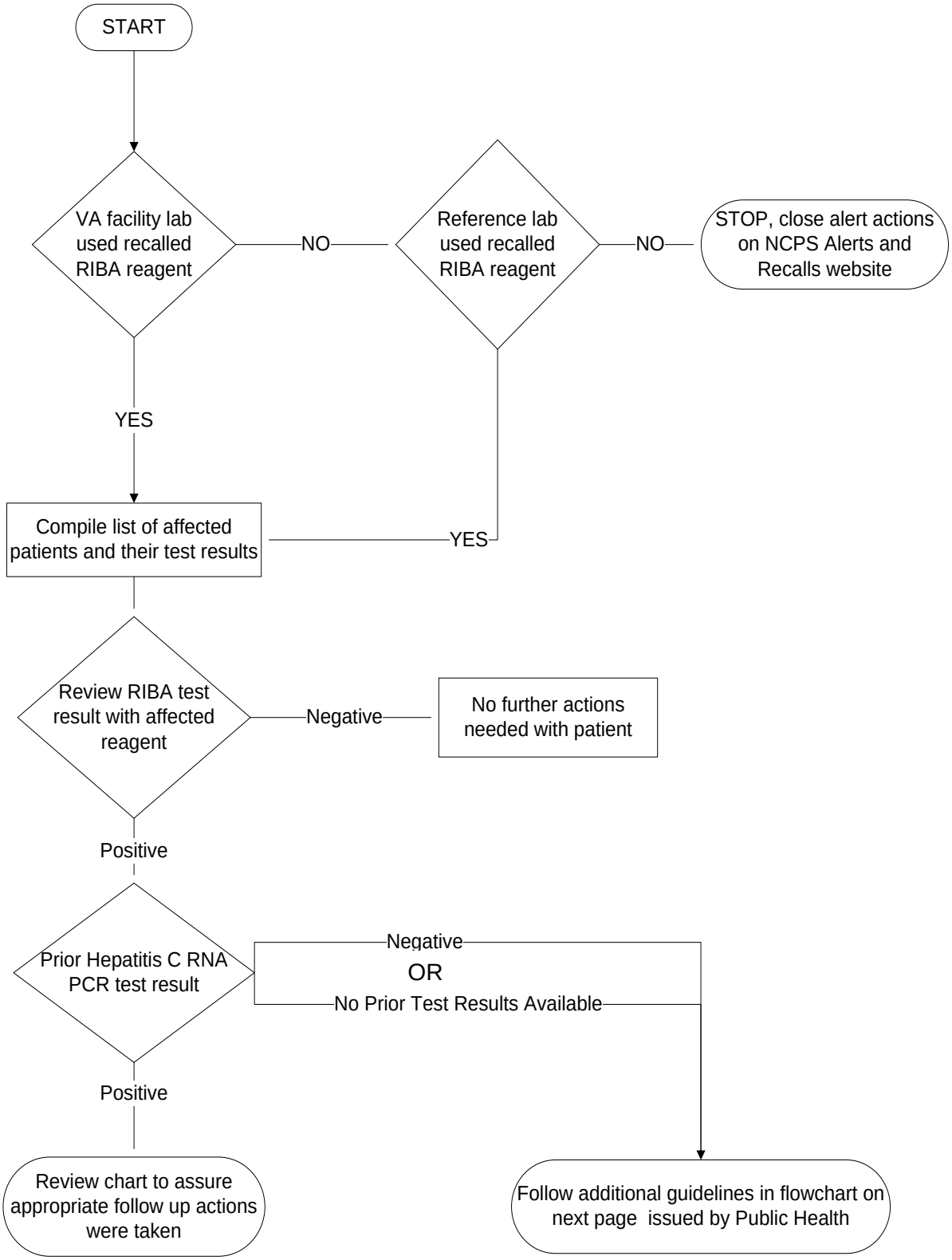
- Ensure that all *Quality Control Procedures* and *Interpretation of Results* are strictly followed per the Instructions for Use directions.
- Discontinue use of any remaining *Chiron*® *RIBA HCV* 3.*0 SIA* kits bearing the specific lot numbers referenced on page 1 of this letter.
- Request a Returned Goods Authorization (RGA) number from Ortho Clinical Diagnostics, Inc., to return any remaining *Chiron*® *RIBA HCV 3.0 SIA* kits bearing the specific lot numbers referenced on page 1 of this letter. Please contact Ortho Clinical Diagnostics at 800-421-3311 (Option 2, 2, 1).
- Return the Ortho Clinical Diagnostics acknowledgement form provided to you with this letter.
- Determine any retesting requirements according to your procedures and assessment of prior test results.

U.S. FDA has been notified of this action. We sincerely apologize for any inconvenience this may cause you.

Sincerely,

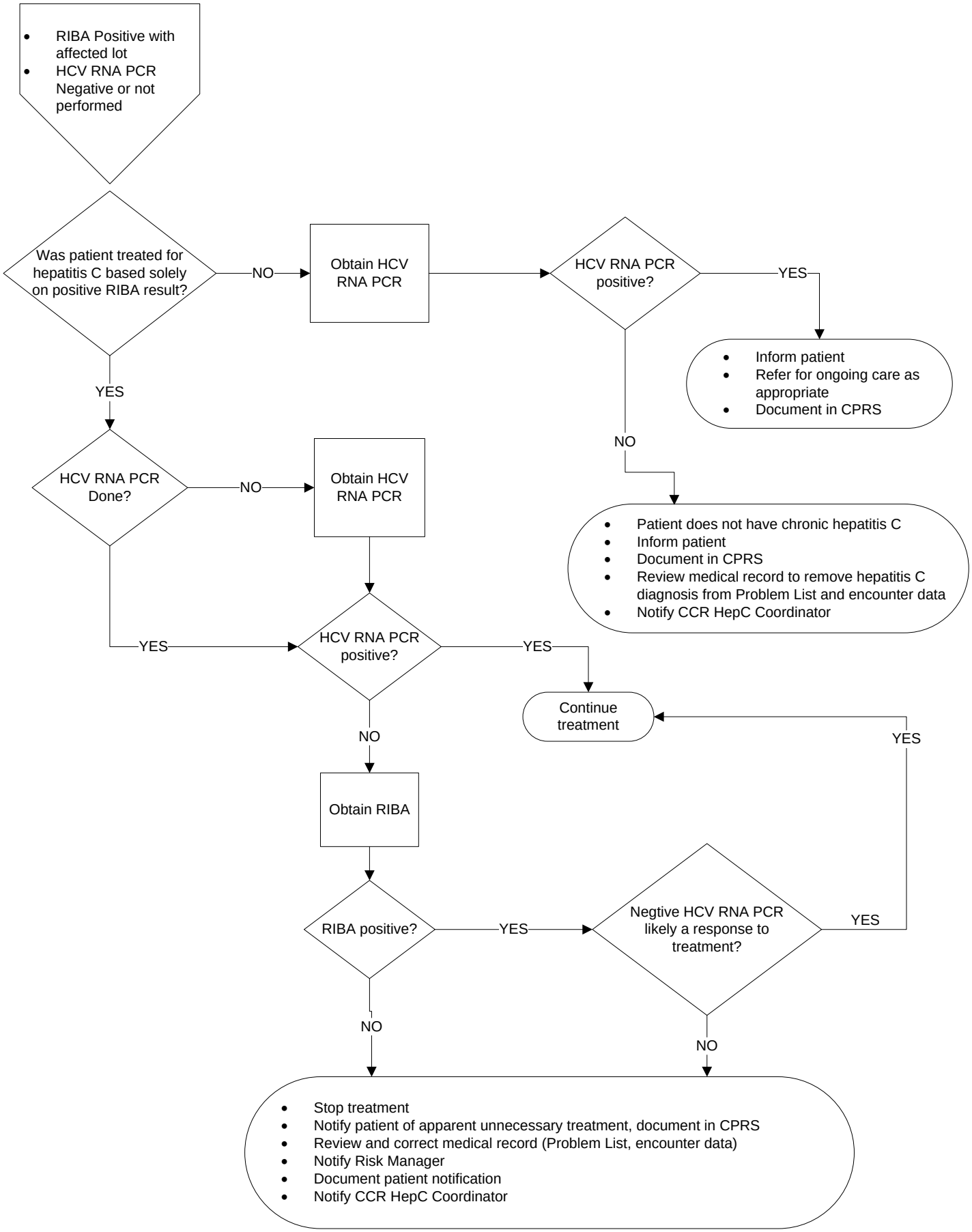
Matthew W. Powell
Vice President, Global Quality Operations, Diagnostics

ATTACHMENT 2 - Guidance Regarding Patients



ATTACHMENT 2 continued

Management of Patients with Positive RIBA using affected reagent lot and no or negative HCV RNA PCR



ATTACHMENT 2 continued

Public Health Strategic Healthcare Group Guidance on Management of Patients with Positive RIBA using Recalled Reagent and No or Negative HCV RNA PCR

Frequently Asked Questions

Q1. What is the clinical issue?
A1. Certain lots of reagent used to perform hepatitis C antibody testing by RIBA have been recalled by the manufacturer based on complaints of false positive result.

Q2. Does this affect only VHA labs?
A2. Reagents may have been used in VHA labs or in reference labs used by VHA. No VHA lab currently has any of the affected reagent lots in use, and records are being reviewed to determine if any were used in the past by VHA or by contract reference labs to conduct testing on VHA patients or employees.

Q3. What time period is covered?
A3. The affected reagents were potentially in use from October 15, 2008 through the present.

Q4. What are the implications?
A4. Clinical implications of false positive RIBA test result include erroneous diagnosis of chronic hepatitis C or, potentially, unnecessary treatment for chronic hepatitis C. RIBA is a test for hepatitis C antibody and is not sufficient to diagnose chronic hepatitis C infection, which requires testing for viremia (usually done using PCR testing.) In addition to clinical concerns, erroneous information in the medical record must be corrected as it may affect issues related to future insurance eligibility, etc.

Q5. Why is RIBA even used if it is not sufficient to diagnose chronic hepatitis C?
A5. While RIBA is not a required element in the VHA diagnostic algorithm for chronic hepatitis C or required under VHA Directive 2009-063 (see references) which requires reflex testing for viremia among patients with positive hepatitis C antibody testing, it may have been in use during some of the period covered by the product recall. In an abundance of caution, we are working with other VHA offices to address this issue.

Q6. What is the role of the hepatitis C Lead Clinician in this process?
A6. The hepatitis C lead clinician may be called on to provide clinical consultation on specific cases. The VHA National Patient Safety Center has issued an alert which directs facilities to identify individual patients affected by this issue. For patients who had a positive RIBA performed with affected lots of reagent, action required will depend on individual clinical scenario. A flow chart listing sequential steps is attached.

ATTACHMENT 2 continued

Q7. What if the patient has an undetectable HCV RNA after receiving treatment, but treatment was administered based on a false positive RIBA and there is no documented HCV RNA prior to treatment?
A7. This is a complicated clinical situation that requires not only clinical judgment but Hepatitis C expertise for evaluation. Without HCV RNA prior to treatment, it is uncertain if the patient ever had chronic Hepatitis C. Although, it is possible that the patient had chronic Hepatitis C in the past and now has successfully completed treatment with a sustained viral response (SVR). Evaluation will require informed clinical judgment, taking into consideration the following factors and it is strongly suggested that an HCV expert is consulted for complete evaluation:

- Overall status and symptoms prior to treatment which suggest hepatitis, including liver function testing and other clinical findings.
- Evaluation of other factors which could affect transaminase levels, such as toxicities associated with prescribed medications or herbal supplements, alcohol use, NASH, autoimmune diseases, hepatitis A or B and other potential causes of elevated transaminases not named here.

In this clinical situation, please contact the Public Health Strategic Health Care Group for further assistance if needed at **publichealth@va.gov**.

Q8. What needs to be modified in the medical record and how do I do it?
A8. Patients found to not have chronic hepatitis C should not have ICD-9 codes in their record (Problem List or encounter data) indicating that they do have the condition. If such codes appear they need to be removed. Guidance for hepatitis C related coding is posted on the VA intranet (see references).

All updates/changes to the electronic health record documentation must be coordinated with your Health Information Management Office. Refer to your local facility's process for correcting the inaccurate laboratory results and any other clinical documents that may contain that data such as the problem list and TIU notes. There are two documents on the VHA HIM web page that have guidance regarding correcting errors in clinical documents. Please refer to http://vaww.vhaco.va.gov/him/faq/FAQNonTIUChngsCorrections.doc and http://vaww.vhaco.va.gov/him/refsresources/PracticeBrief3ErroneousDocCorrections.doc for further information.

Additional resources/references:
The VHA's main portal for information related to hepatitis C is on the VA intranet at http://**vaww.hepatitis.va.gov**

- Flow chart for hepatitis C antibody screening: http://vaww.hepatitis.va.gov/vahep?page=prtop02-ct-chart
- VHA Directive 2009-063, November 25, 2009 -- Reflex Confirmatory Testing for Chronic Hepatitis C Virus Infection: http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2121

- ICD-9 coding for hepatitis C: http://vaww.vistau.med.va.gov/Documents/CCR/CCR_ICD-9_Coding_Hepatitis_C_FC_0909.pdf

ATTACHMENT 3 - Guidance Regarding Employees and Other Individuals

For the purpose of this Patient Safety Alert, “Employee” refers to applicants, current and former employees, volunteers, academic affiliates and other who work at the facility and may have been tested for hepatitis C.

For individuals who had a positive antibody result on RIBA, where the test was conducted using the affected reagents, then the following actions should be taken:

1. For applicants who were tested for hepatitis C as part of their pre-placement examination and who had a positive RIBA test, a letter should be sent notifying them of the possible false positive results and recommending that they follow-up with their private physician. Document the recommendation in the employee’s medical file.

2. For current employees who were tested for hepatitis C as part of their pre-placement examination and who had a positive RIBA test, notify the employee that they should have the test repeated by their primary care physician. Document the recommendation in the employee’s medical file. This may require requesting the former employee's medical file from National Archives and Records Administration.

3. For current employees who were tested as part of a baseline post bloodborne pathogen exposure evaluation and who had a positive RIBA test, notify the employee that they should have the test repeated by their primary care physician. Document the recommendation in the employee’s medical file.

4. For current employees who were tested as part of a follow-up post bloodborne pathogen exposure evaluation and who had a positive RIBA test, notify the employee that they should have the test repeated by their treating physician. Document the recommendation in the employee’s medical file.

5. If, as a result of a false positive test, an employee or former employee has filed a workers’ compensation claim for hepatitis C, they should notify the Department of Labor of the possible change in their health status.