



Health Protection Agency

CJD Section  
Centre for Infections  
Health Protection Agency  
61 Colindale Avenue  
London NW9 5EQ

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To: Chief Executives of Trusts

## **Pre-surgical assessment for variant Creutzfeldt-Jakob Disease (vCJD) risk in neurosurgery and eye surgery units**

Dear Colleague,

Your hospital should already be using Annex J of the [ACDP TSE Working Group Infection Control guidance](#)<sup>a</sup> to find out whether any patients who are about to undergo surgery or endoscopy may be at increased risk of being infected with CJD. If a patient is found to have an increased risk of CJD prior to their surgery or endoscopy then special infection control precautions may need to be taken.

We are writing to inform you that Annex J of the TSE Infection Control guidance has recently been revised, and now advises that patients who are due to have high risk surgery<sup>b</sup> or neuro-endoscopy should be asked whether they have received transfusions of blood or blood components from 80 or more donors since 1980. This is because these patients may have an increased risk of being infected with variant CJD (vCJD), and special infection control precautions should be followed for their high risk surgery or neuro-endoscopy. This may involve destroying surgical instruments.

If a patient is found to have an increased risk of vCJD due to receipt of blood from 80 or more donors, this information should be marked on their medical records, and the patient will need to be informed of their increased risk via the HPA and their GP.

**Please forward this letter and enclosed document to the leads for surgery, haematology and infection control in your trust.** Please inform these individuals about this new guidance, even if your trust does not carry out high risk surgery or neuro-endoscopy.

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<sup>a</sup> <http://www.dh.gov.uk/ab/ACDP/TSEguidance/index.htm>

<sup>b</sup> High risk surgery is defined as surgery involving any of the following organs or tissues (high risk tissues): brain, spinal cord, dura mater, cranial nerves (specifically the entire optic nerve and only the intracranial components of the other cranial nerves), cranial nerve ganglia, posterior eye (specifically the posterior hyaloid face, retina, retinal pigment epithelium, choroid, subretinal fluid, optic nerve) and pituitary gland

Details of how the pre-surgical assessment should be carried out are contained in the accompanying document 'Pre-surgical assessment for vCJD risk in neurosurgery and eye surgery units. Information for clinicians'. This and all other documents relating to this assessment process are available on the HPA website<sup>c</sup>.

These actions should only be carried out for the relatively small number of patients who require surgery or neuro-endoscopy on high risk tissues. The assessment is likely to identify 50 or so of these patients in the UK each year who have had transfusions from 80 or more donors. However, the blood transfusion history for many patients may need to be reviewed in order to identify those few who have received blood from 80 or more donors.

**Please now take the following actions:**

1. Ensure that departments carrying out high risk surgery or neuro-endoscopy use Annex J of the ACDP TSE Working Group Infection Control guidance to assess their pre-surgical patients and identify those who may have received a large number of blood transfusions.
2. The infection control team should lead this process.
3. Ensure that surgical departments work with the hospital blood transfusion laboratory to obtain patients' full transfusion histories. They should use the 'vCJD highly transfused risk assessment form'.
4. Ensure that the hospital blood transfusion laboratory collaborates with other transfusion laboratories to obtain details of patients' treatments received elsewhere.
5. Ensure that the infection control team, the blood transfusion lead and haematologists agree a process for assessing patients who have uncertain or incomplete transfusion histories.
6. Ensure that the infection control team is aware of patients who may have received blood from 80 or more donors and manages them as 'at increased risk of vCJD'. The ACDP TSE Working Group Infection Control guidance should be followed for these patients. This may require destroying surgical instruments.
7. Ensure that the infection control team informs the HPA Centre for Infections CJD Section of any patients assessed as having an increased risk of variant CJD. The CJD Section will contact the patients' general practitioners and ask them to inform their patient(s) that they have an increased risk of vCJD.

**The clinical care of patients who have an increased risk of vCJD should not be compromised in any way.**

If your trust carries out high risk surgery or neuro-endoscopy, please ask the surgical, transfusion and infection control teams to participate in a forthcoming evaluation of this pre-surgical assessment process on behalf of the CJD Incidents Panel. This will involve these teams keeping copies of risk assessment forms and completing short questionnaires.

If you would like to ask any questions, please contact the CJD Section at the Health Protection Agency's Centre for Infections (Colindale) by e-mail to [cjd@hpa.org.uk](mailto:cjd@hpa.org.uk) or by phone on 020 8327 6074/6411.

<sup>c</sup> <http://www.hpa.org.uk/vCJDpresurgicalassessment>

## **Rationale**

The vCJD risk to these patients is uncertain, and depends on the prevalence of subclinical variant CJD infection among blood donors, the infectivity in the blood of infected donors, and the number of donors these patients have received blood from. The CJD Incidents Panel<sup>1</sup> and the ACDP TSE Working Group<sup>2</sup> have advised the Department of Health to manage this risk by focusing on patients who require surgery or neuro-endoscopy on high risk tissues.

There are two reasons why we advise you to identify these patients who may have been exposed to a possible risk to vCJD. Firstly, we want to be open with patients about their possible health risks. While such news may be distressing, patients may wish to know about health risks that they may have been exposed to, even though these risks are very uncertain.

Secondly, it is necessary to take public health precautions to prevent further spread of vCJD to other patients. Patients who have received blood from 80 or more donors are not eligible to be blood donors themselves (as they have received blood transfusions in the UK since 1980). They could, however, pose a risk to other patients if they are infected with vCJD and undergo surgery. This is because the surgical instruments may become contaminated with abnormal prion protein (the agent which causes vCJD), and this might not be removed during reprocessing of the instruments. Surgery on high risk tissues is thought to be the main possible route by which these patients could spread vCJD infection to other patients.

We realise that it may seem inequitable or incomplete to only identify patients who have received blood from 80 or more donors if they require surgery on high risk tissues. We advise you to do this because the estimated risk to patients who have received large numbers of blood transfusions is so uncertain. The assessment of the vCJD risk to these patients may change if new estimates of vCJD prevalence and transmissibility are developed.

If all patients who have received blood from 80 or more donors were to be identified and informed that they have an increased risk of vCJD, then a great many might be unnecessarily distressed and alarmed. This is because there is a good chance that future prevalence and transmissibility estimates will be lower than they are now. If the cut off limit used to identify patients as at increased risk of vCJD should fall, many patients would have to be contacted and told that their risk of vCJD is not as great as was previously thought.

By reducing the scale of the pre-surgical assessment, we will limit the number of people who may have to go through this process. This pre-surgical assessment process aims to strike a balance between reducing the possible vCJD infection risk and causing alarm to patients and disruption for hospitals. We hope that this discussion of the issues will help you to implement this guidance.

Yours sincerely,



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Epidemiologist,  
Health Protection Agency  
(Centre for Infections)

Mr David Pryer  
Chairman of the CJD  
Incidents Panel

Professor Don Jeffries  
Chairman of the ACDP  
TSE Working Group

### Enclosed document

'Pre-surgical assessment for high risk [surgery or neuro-endoscopy](#) to identify highly transfused patients at increased risk of variant CJD (vCJD): Information for healthcare staff'

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<sup>1</sup> The CJD Incidents Panel is an expert committee established on behalf of the UK Chief Medical Officers in 2000. Its terms of reference include:

'To assist all those bodies responsible for the provision and delivery of healthcare to decide on the most appropriate action to take to handle incidents involving potential transmission of Creutzfeldt-Jakob Disease (CJD) and variant CJD (vCJD) between patients through clinical interventions, including via surgical instruments, tissues, organs and blood and to keep the relevant devolved administrations informed.

To consider what information should be collected on patients who may have been exposed; advise on what studies or follow-up may be needed; advise Directors of Public Health on patient tracing and notification exercises where these are indicated; and advise on whether any other measures are needed to protect the wider public health.'

<sup>2</sup> As part of its remit, the ACDP TSE Working Group produces the guidance document "Transmissible Spongiform Encephalopathy Agents: Safe Working and the Prevention of Infection". The aim of the guidance is the minimisation of the risk of transmission of CJD and vCJD.