Guidelines for the Blood Transfusion Services

10.1: General considerations

http://www.transfusionguidelines.org/red-book/chapter-10-investigation-of-suspected-transfusion-transmitted-infection/10-1-general-considerations

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The guidelines in this section apply to reports of possible transfusion-transmitted infection (TTI) arising from blood or blood components supplied by the UK Blood Transfusion Services. Any suspected cases of TTI should be documented and fully assessed to determine whether further investigation of donors and/or donation samples is required or warranted. The guidance contained within this section covers the action to be taken by blood services in such cases.

Suspected cases of bacterial contamination of blood components may be notified by reports from the hospital of a significant transfusion reaction or, following a reaction, the identification of bacteria either within the pack or in a patient's blood culture. Reports will normally be received close to the time of transfusion of the blood component, when other components from the same blood donation may be in stock at either a Blood Centre or a hospital.

Because non-bacterial TTI may be asymptomatic, cases may not be recognised or detected until months or years after the transfusion. Many cases come to light through incidental screening of a patient who has received a blood component transfusion in the past or specific testing on development of late clinical features of the infection in question. Cases may therefore be notified by sources other than the hospital blood transfusion laboratory, but close liaison will be required with the reporting clinician and with the hospital blood transfusion laboratory that supplied the blood component(s) for transfusion.

10.1.1: Documentation

Reports of possible TTI must be recorded and retained. Details of the notification should be confirmed in writing by the reporter. For each report, confirmation of clinical and laboratory details will be required. Ideally, these should take the form of copies of the relevant recipient blood tests and computer printouts of transfusion records. Other forms of reporting of donation numbers (by letter, typed lists etc.) should be avoided in view of the risk of transcription errors.