

From the Chief Medical Officer
Dr Henrietta Campbell CB



Department of
**Health, Social Services
and Public Safety**

An Roinn

**Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí**

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Your Ref:
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URGENT COMMUNICATION

HSS(MD)21/2004

To:

All General Practitioners
Chief Executives, Health and Social Services Boards
Chief Executives, Health and Social Services Trusts (*for onward dissemination to Risk Manager, Health & Social Services Trusts*)
Medical Directors, Health and Social Services Trusts (*for onward dissemination to all clinicians who use endoscopy*)
Directors of Nursing, Health and Social Services Boards
Directors of Nursing, Health and Social Services Trusts (*for onward dissemination to all theatre nurses, infection control nurses and nurses working in endoscopy units*)
Decontamination Leads, Health and Social Services Trusts
Consultants in Communicable Disease Control
Directors of Public Health, Health and Social Services Boards (*for onward dissemination to all general practitioners*)
Dr Brian Smyth, Regional Epidemiologist CDSC(NI)

Dear Colleague

UPDATE ON DECONTAMINATION OF ENDOSCOPES

Key Messages

- The media coverage of this issue is sure to have caused considerable public anxiety in relation to endoscopic procedures. It is important that patients are assured that the endoscopes used are now being decontaminated to the required standards. Any scope about which there have been concerns raised has either been immediately withdrawn from service or subjected to revised decontamination procedures.
- The beneficial role of gastrointestinal endoscopy for the prevention, diagnosis and treatment of many digestive diseases and cancer is well established. The risk of transmission of any infection at endoscopy is estimated at 1 in 1.8 million procedures; the risk of transmission of blood borne virus infections is much lower than this.
- A regional team supported by national and international experts has undertaken a detailed investigation into decontamination concerns surrounding a small number of endoscopes. As a result some patients from two hospitals - Royal Group Hospitals Trust and Whiteabbey Hospital - are to be offered testing for blood borne virus infection as a precautionary measure. A further group of patients from Antrim Area Hospital and Lagan Valley Hospital will receive a letter offering them reassurance and advice about their endoscopic procedure. At this time it is not expected that this group of patients will require testing for blood borne viruses.

1. The purpose of this communication is to update you on the regional investigation undertaken in relation to the decontamination of endoscopes since my previous communication of 15th June 2004 (Ref: HSS(MD)20/2004) advising you that the Department has undertaken a comprehensive review of decontamination of endoscopes in all Trusts. This review indicated potential problems with a small number of scopes that were in use in three Trusts, namely Down & Lisburn Trust, Royal Group of Hospitals Trust and United Hospitals Trust.
2. The risks of transmission of blood borne virus infection at endoscopy are very low. The international data in the peer-reviewed literature indicates that, to date, there have been 3 cases of HCV associated with failure to decontaminate colonoscopes; 1 case of HCV associated with failure to decontaminate a duodenoscope and 1 case of Hepatitis B associated with failure to decontaminate a duodenoscope. There are no known cases of HIV transmission associated with endoscopy.
3. Over the last week a full and detailed investigation has been undertaken by a Regional Team, convened by myself. In addition to representatives from the Trusts involved members of this team have included specialists in public health, decontamination, infection control, virology and endoscopy. The principal remit of this team was to undertake a risk assessment to determine if any patients had been put at risk of blood borne virus (HIV, Hepatitis B (HBV), Hepatitis C (HCV)) infection as a result of endoscope decontamination concerns. To support and advise the regional investigation the Health Protection Agency (HPA), London, convened an Expert Advisory Group bringing together national experts in blood borne viruses, infection control, decontamination and endoscopy. Advice was also sought from international experts.
4. Full details of the risk assessment and the recommendations of the Expert Advisory Group are included at Annex A.
5. The investigation revealed some shortcomings in the decontamination processes for a small number of scopes at four hospitals in three Trusts here – Down & Lisburn Trust (Lagan Valley Hospital), Royal Group of Hospitals Trust, United Hospitals Trust (Antrim Area Hospital and Whiteabbey Hospital). However the risk of any patient acquiring a blood borne virus infection as a result is extremely low indeed.

Action being taken by Down & Lisburn Trust, Royal Group Hospitals Trust and United Hospitals Trust

6. A total of 685 patients in the Royal Victoria Hospital and 637 patients from Whiteabbey Hospital will be contacted and offered testing for blood borne viruses as a precautionary measure.

7. To date neither Lagan Valley Hospital or Antrim Area Hospital have identified any patients who need to be contacted and offered testing for blood borne virus infection. However over 1500 patients at Antrim Hospital and over 200 patients from Lagan Valley Hospital will be contacted by the Trusts and offered reassurance and advice in relation to their endoscopy at the trust. At this time it is not expected that these patients will require testing for blood borne virus infection. In the event that patients contacted in this way request further information, and/or testing for blood borne virus infection, Trusts will make this available to them.
8. Details of the risk assessment for the scopes used at these hospitals are included at Annex A.
9. The Northern Ireland Endoscopy Information line 0800 912 0099 is available to patients who need further reassurance or general information. If patients require further specific information their contact details will be sent to the relevant Trust who will then contact them.

Restoring Confidence in Endoscopy

10. Endoscopy is a vital procedure that is used in the diagnosis and treatment of many serious illnesses, including gastrointestinal bleeding and cancer. Patients should be reassured that the benefits of an endoscopic procedure far outweigh the extremely low risk of infection from that procedure.
11. In order to restore public confidence in the use of endoscopes in our hospitals, the Department has commissioned an independent External Review to examine the complex issues associated with current situation and make recommendations for the future.

Yours sincerely



Dr Henrietta Campbell
Chief Medical Officer

cc: Permanent Secretary, DHSSPS
Miss J Hill, Chief Nursing Officer, DHSSPS
Dr N Morrow, Chief Pharmaceutical Officer, DHSSPS
Dr E Mitchell, Principal Medical Officer, DHSSPS
Dr G Mock, Principal Medical Officer, DHSSPS
Dr L Doherty, Senior Medical Officer, DHSSPS
Dr H Neagle, Medical Officer, DHSSPS
Mr D Sullivan, Director of Secondary Care, DHSSPS
Mr J Livingstone, Director of Primary Care, DHSSPS
Mr C Shannon, Information Office, DHSSPS
Mr K Mulhern, Information Office, DHSSPS

This letter is available at www.dhsspsni.gov.uk and also on the DHSSPS Extranet which can be accessed directly at <http://extranet.dhsspsni.gov.uk> or by going through the HPSS Web at <http://www.n-i.nhs.uk> and clicking on DHSSPS.

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ANNEX A

Summary of Outcome of Regional Investigation of Decontamination of Endoscopes

1. The investigation has revealed a number of decontamination shortcomings in relation to 16 endoscopes in four hospitals in three Trusts. To understand these issues it is necessary to be aware that decontamination requirements for all endoscopes are that they undergo an appropriate cleaning process followed by high level disinfection or sterilization (full details available in Device Bulletin DB (NI) 2002/05, "Decontamination of Endoscopes"). The decontamination shortcomings fall into 2 main classifications as follows:

A: Endoscopes in which one narrow channel may not have been fully cleaned or disinfected, despite going through the normal cleaning and disinfection process. In this group there were five gastroscopes at the Royal Victoria Hospital, and four colonoscopes at Whiteabbey Hospital.

B: Endoscopes in which all channels had been cleaned, but one had not been disinfected. In this group there were two duodenoscopes at Lagan Valley Hospital and four duodenoscopes and one gastroscope at Antrim Area Hospital.

2. The Health Protection Agency (HPA) Expert Advisory Group has given the following advice in relation to each of these classifications and the overall risk of blood borne virus transmission:

General Advice: The risks of transmission of blood borne virus infection at endoscopy are very low. The international data in the peer-reviewed literature indicates that, to date, there have been 3 cases of HCV associated with failure to decontaminate colonoscopes; 1 case of HCV associated with failure to decontaminate a duodenoscope and 1 case of Hepatitis B associated with failure to decontaminate a duodenoscope. There are no known cases of HIV transmission associated with endoscopy.

Endoscopes in the first Classification: Although the risk is very low, a full patient notification exercise should be undertaken for these patients and they should be offered testing for blood borne virus infection.

Endoscopes in the second Classification: The risks of transmission of blood borne viruses is extremely low and thus only those patients where the endoscope was possibly in recent contact with a blood borne virus should be notified and offered testing.

3. The Regional Incident team have accepted the Expert Advisory Groups advice and have made recommendations for the Trusts. In the interests of public reassurance the Regional Team have concluded that for endoscopes in the second classification, in addition to contacting patients where the endoscope was possibly in recent contact with a blood borne virus, all other patients should be contacted and offered reassurance.

The following action is being recommended for each of the three Trusts as follows:

A. Down & Lisburn Trust

Two duodenoscopes used at the Trust have been determined to be in the second classification. To date the Trust have not identified any circumstances in which one of these scopes could have been in contact with a blood borne virus. The Trust should contact the patients who do not need to be recalled for testing and offer them reassurance and advice.

B. Royal Group of Hospitals Trust

Five gastroscopes used at the Trust have been determined to be in the first classification. A full patient notification exercise is required for all the patients scoped using these gastroscopes.

C. United Hospitals Trust

- (i) Four colonoscopes used at Whiteabbey Hospital have been determined to be in the first classification. A full patient notification exercise is required for all the patients scoped using these scopes.
- (ii) Four duodenoscopes and one gastroscope used at Antrim Area Hospital have been determined to be in the second classification. To date the Trust have not identified any circumstances in which one of these scopes could have been in contact with a blood borne virus. The Trust should contact the patients who do not need to be recalled for testing and offer them reassurance and advice.