Transfusion-Transmitted Infections (TTI)

FIGURES FROM THE ANNUAL SHOT REPORTS 2020-2022

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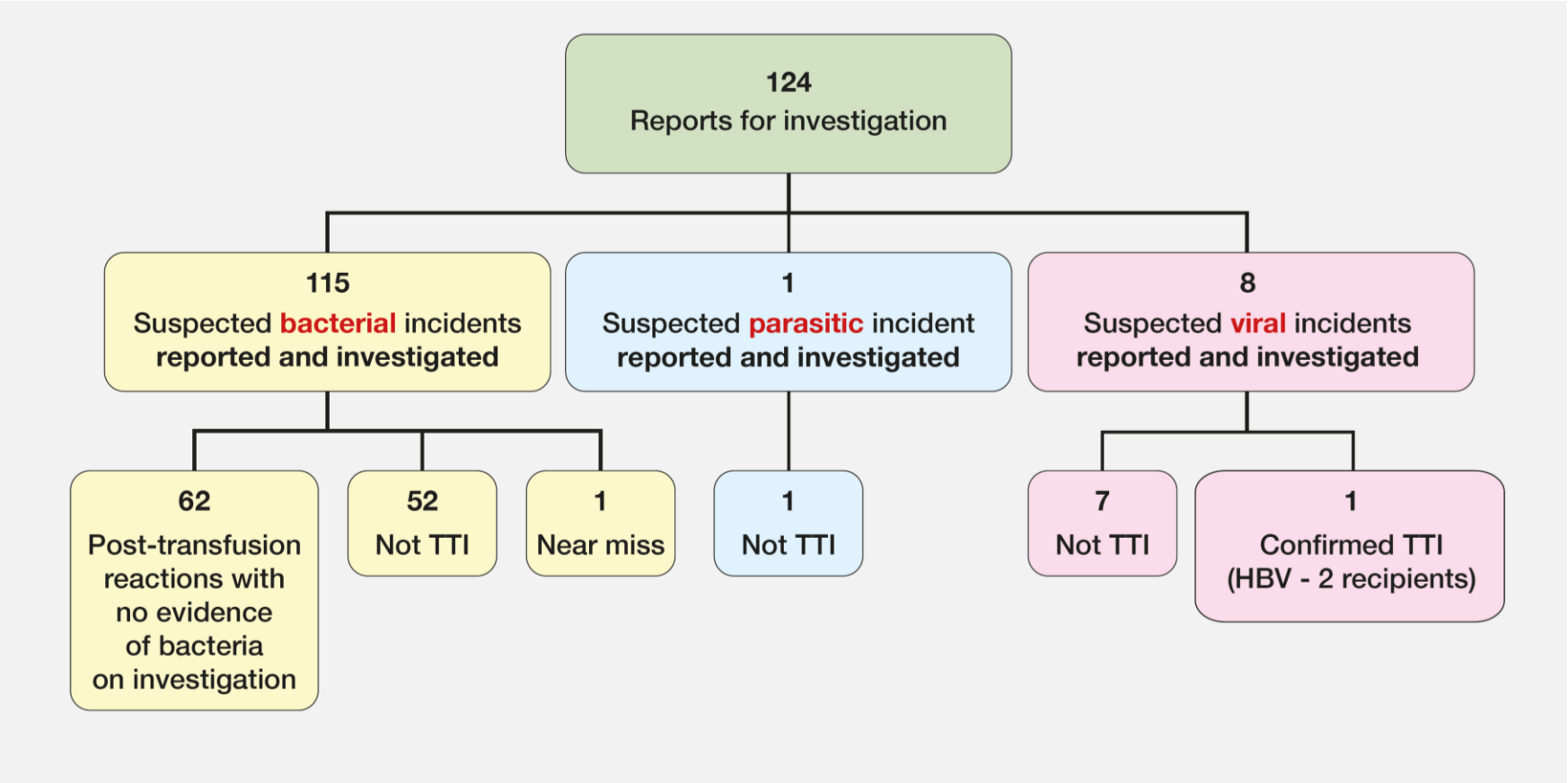
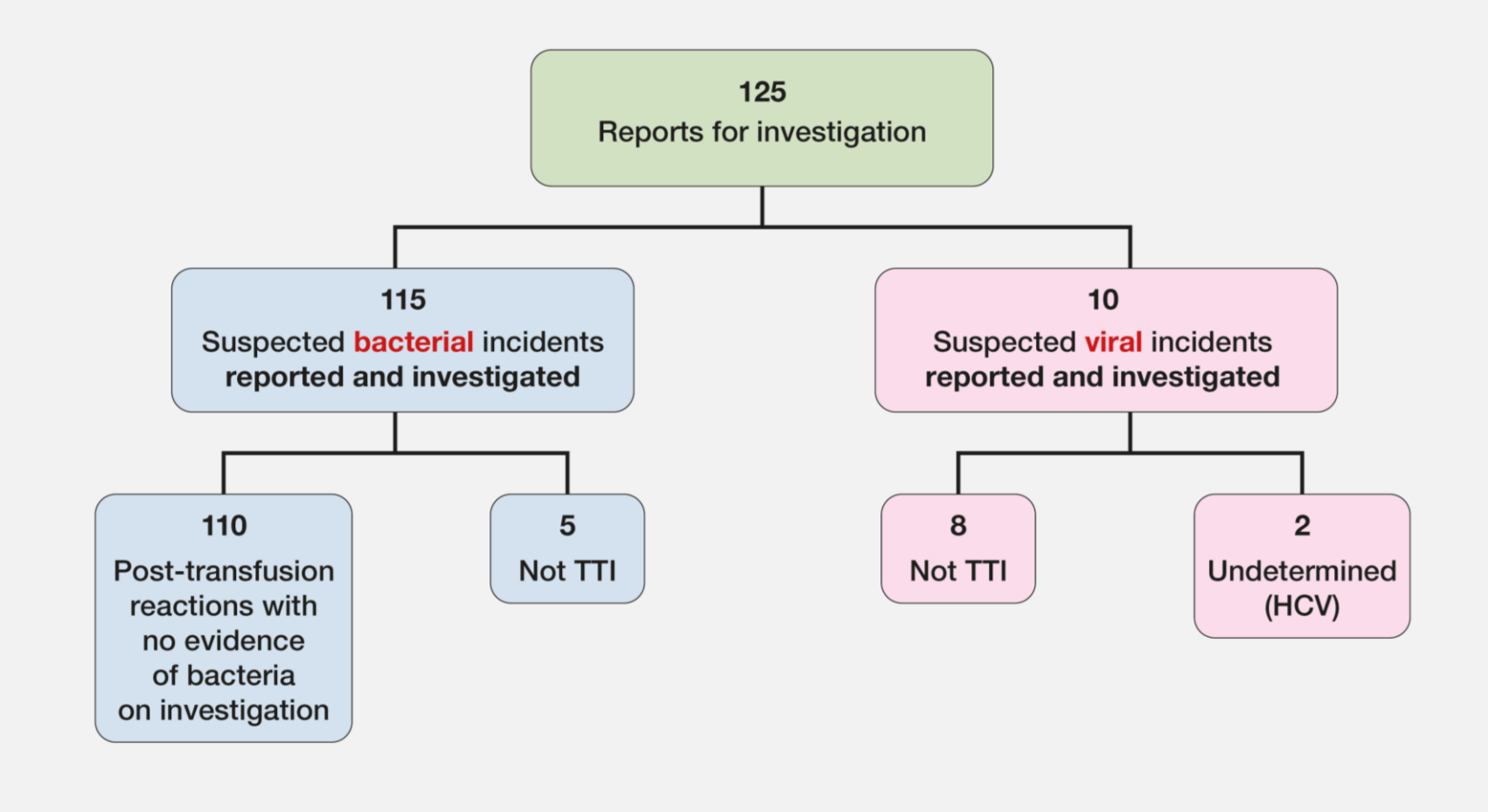
Outcome of suspected TTI investigated by the Blood Services in England, Northern Ireland, Scotland and Wales reported to the NHSBT/UKHSA Epidemiology Unit by the end of 2022



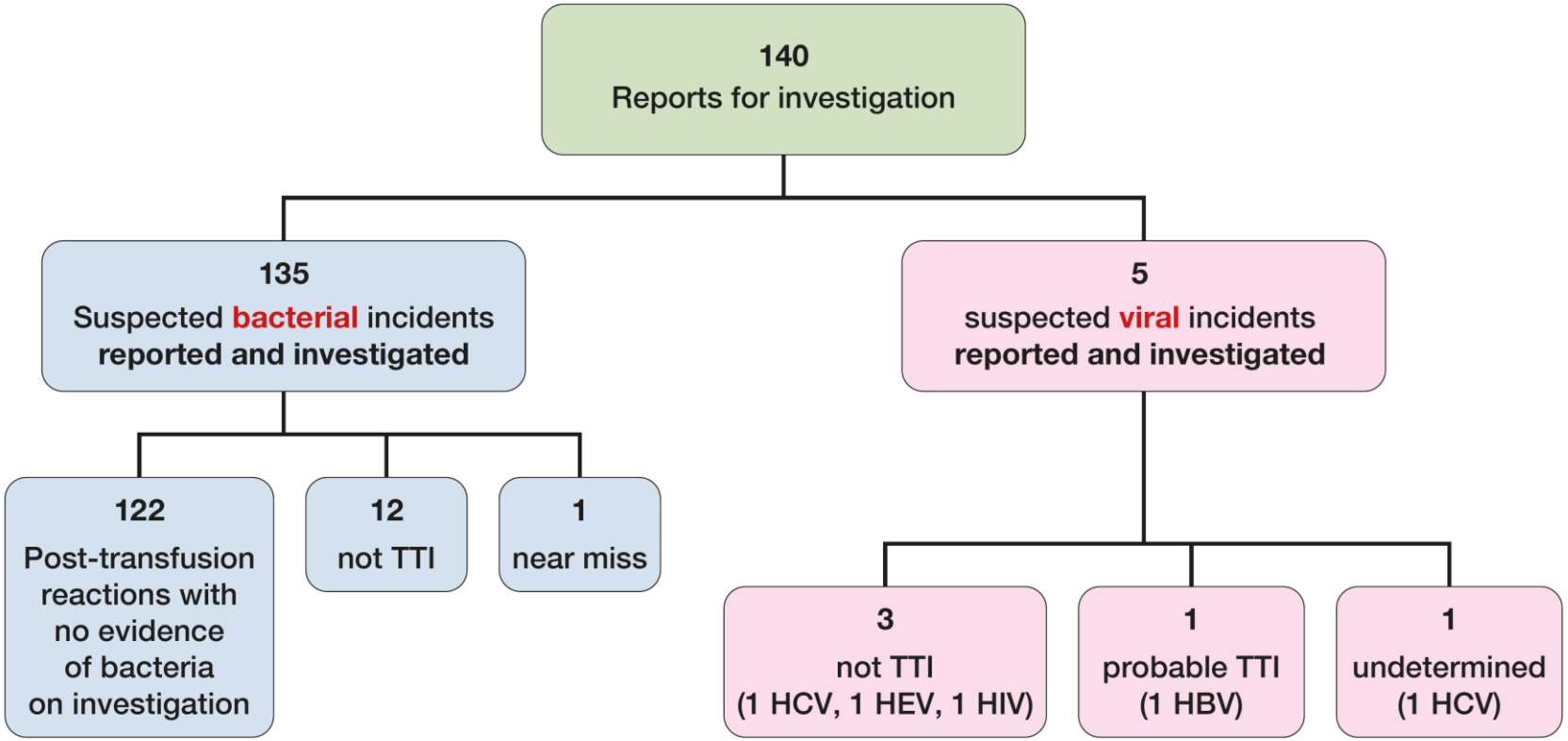
TTI=transfusion-transmitted infection; HBV=hepatitis B virus

Outcome of reports of suspected TTI made to the NHSBT/PHE Epidemiology Unit in 2021



TTI=transfusion-transmitted infection; HCV=hepatitis C virus

Outcome of reports of suspected TTI made to the NHSBT/PHE Epidemiology Unit in 2020



TTI = transfusion-transmitted infection; HCV = hepatitis C virus; HEV = hepatitis E virus; HIV = human immunodeficiency virus; HBV = hepatitis B virus

Note:

- *The undetermined HCV case was related to donations from 1990, which was before HCV screening was introduced*
- *A PTR occurs when a blood transfusion recipient develops a reaction following a transfusion and bacteria were suspected. However, no bacteria were cultured in the recipient, units or donor(s), i.e. no evidence of any bacterial contamination*
- *A confirmed TTI is classified as in the above TTI definition with evidence that the virus/bacterium is indistinguishable on molecular typing between patient and donor/pack*
- *A probable TTI is classified as a TTI as in the above definition, but where molecular typing cannot be carried out to confirm this*
- *Not a TTI is defined as an investigation that concluded the infection in the recipient was NOT caused by transfusion, either as no infected donors identified (after all donors traced) or bacteria/virus identified in the recipient, but all units cleared (no bacteria/virus) in the unit and/or implicated donors*
- *A near miss is defined as either an infection was identified in the unit due to be transfused however the unit was NOT used in transfusion (e.g. bacterial growth seen in unit and returned to bacteriology laboratory prior to transfusion for investigation) or an infected donor calls post donation, and the unit is recalled and infection found in unit before it is transfused*