

Medical Directors, NHS Boards
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Dear Colleague

Risk of Ebola Virus Disease (EVD) transmission from Ebola Survivors

You will be aware of recent documented evidence of sexual transmission and of recrudescence of Ebola disease in survivors. In light of this I am writing to inform you of the current information about possible viral persistence in certain body sites and the advice from the Advisory Committee on Dangerous Pathogens (ACDP) on appropriate management of Ebola survivors. This advice is only for people who have had Ebola disease; contacts of Ebola cases who are outside the 21 day incubation period are not considered to pose any additional risk. Please distribute this letter among your colleagues as appropriate.

The risk of Ebola infection from an Ebola survivor as a result of general daily contact is very low indeed and is further reduced by measures put in place to care for Ebola survivors should they become unwell or require elective medical interventions.

All known Ebola survivors in the UK have been assigned a local Infectious Disease (ID) unit and a named clinical lead with whom they should maintain contact. If a survivor becomes ill with symptoms suggestive of infection, current guidelines are that they should contact that ID unit for advice, rather than going to their GP in the first instance.

If a patient presents with non-infectious symptoms or accident/emergency situation (for example having been involved in a road traffic accident) they should provide the clinicians managing their treatment with details of their assigned ID unit so they can seek advice. Likewise in the case of elective surgery, including dental surgery, the clinician should seek the patient's consent to discuss the case with the relevant ID unit.

**From the Chief Medical Officer
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Please cascade to those in your organisations with an interest.

Addresses

For action

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This is particularly important for elective surgical procedures on high-risk sites where viral persistence seems most likely (e.g. central nervous system, eye, prostate). This would enable a risk assessment to be carried out and mitigating actions to be taken where possible.

In the event that use of Personal Protective Equipment (PPE) is advised by an assigned ID unit, clinicians experienced in using it (e.g. from the assigned ID unit) should train those undertaking surgery. The infection risk is likely to be very low for routine medical care, so standard infection control precautions should provide adequate protection in most circumstances.

Epidemiological data suggests that human transmission chains are predominantly driven by direct body or body fluid contact from infected patients. However, evidence from the West African outbreak indicates that previously recognised maximum time periods from symptom onset to last positive detectable ribonucleic acid (RNA) underestimate virus persistence in a number of sites. Most of these are immunologically protected sites and some now appear, albeit very rarely, to be linked to disease transmission.

Our current understanding of the evidence is set out in the table below.

Evidence summary - EVD survivor risk
<ul style="list-style-type: none"> • Viral persistence and recrudescence of EVD can occur. In known cases it has often been associated with, but not limited to, immune protected sites. This is consistent with knowledge of other viral illness, particularly Filoviridae.
<ul style="list-style-type: none"> • The greater the time from the original onset of EVD symptoms, the lower the risk of viral persistence. There is not currently a documented case of viral persistence 1 year after (acute) infection.
<ul style="list-style-type: none"> • Survivors with positive Polymerase Chain Reaction (PCR) tests for body fluids other than breast milk or semen, and therefore with potentially transmissible infection, are usually ill and symptomatic at presentation/re-representation.
<ul style="list-style-type: none"> • There are currently only 2 documented cases of recrudescence viraemia. The risk is clearly very low, though under-reporting is possible.
<ul style="list-style-type: none"> • Where an immune privileged site is implicated as a source of infection, the presence of circulating neutralising antibody may minimise the length of time blood remains PCR positive and therefore reduce transmission risk.
<ul style="list-style-type: none"> • The two sites where there may be a 'routine' domestic risk of transmissibility are male testes or prostate (through semen) and female breasts (through breast milk). There are currently only two documented cases worldwide of sexual transmission of EVD. Direct infection of infants through breast milk rather than body contact is difficult to quantify due to natural maternal proximity but the absence of late cases means the risk must be low.
<ul style="list-style-type: none"> • The infectivity of patients with persistent or recrudescence PCR positive body fluids remains largely unknown but appears low given the lack of recurrent disease outbreaks in either the current West African cohort of >17,000 survivors or the combined previous epidemics.
<ul style="list-style-type: none"> • There have been no secondary cases in community or healthcare workers from initial or recrudescence disease management to date in the UK.
<ul style="list-style-type: none"> • There have been no documented cases of EVD transmission through transfusions or donated tissues or organs. As a precautionary measure ACDP has advised against any donation pending review by the Advisory Committee on the Safety of Blood, Tissues, and Organs (SaBTO).

Many thanks for disseminating this important message to appropriate contacts.

Yours sincerely

CATHERINE CALDERWOOD
Chief Medical Officer