



## **Advisory Committee on Dangerous Pathogens**

### **Draft New Guidance: 'Management of Hazard Group 4 Viral Haemorrhagic Fevers and similar human infectious diseases of high consequence'.**

#### **Summary**

The new guidance replaces the previous ACDP publication 'Management and Control of Viral Haemorrhagic Fevers' which was published in 1996. It is based upon up to date scientific and epidemiological evidence on the risks of transmission of the viral haemorrhagic fevers (VHFs) and seeks to encourage early consideration of VHF in the differential diagnosis of patients who present with high fever and who have had a relevant travel exposure.

New in the guidance is practical advice on the handling of patient samples that reflect developments in laboratory diagnostic techniques and recognition of the need for greater flexibility in the management of patients in whom a VHF is confirmed. The new risk assessment algorithm is designed to link staff protection and infection control measures to the assessment of risks presented by the patient.

The guidance has been subject to a technical consultation and responses received have helped to shape this final draft document and keep it relevant and practical.

Members are asked to consider this draft and agree its publication, subject to any suggested amendments. It is intended that, subject to any amendments, the guidance will be published on the ACDP website and disseminated to relevant bodies with a special interest.

#### **Main points**

##### *Patient Risk Assessment*

VHFs are rare in the UK and the majority of patients who return with fever from endemic areas will have malaria or other infection and will not have VHF. However, the consequences of failing to detect VHFs early and protect staff appropriately are potentially severe and therefore early consideration of VHF in the differential diagnosis is to be encouraged. This also encourages early malaria testing and this brings the benefit of early treatment. Subject to local risk assessment, patients who are categorised only as 'possibility of VHF', and whose condition indicates a low index of suspicion of VHF, require isolation in side room until VHF infection has been discounted but can be cared for with the application of standard infection control precautions and diagnostic samples can be handled locally using standard procedures whilst waiting for the results of malaria and VHF screening.

Patients in whom there is a higher index of suspicion and who are therefore categorised as 'high possibility of VHF' need to be isolated in a side room and enhanced infection control procedures put in place to protect staff until the possibility of VHF infection has been discounted or confirmed. Transfer to a specialist high security infectious disease unit is only recommended for those patients in whom infection is confirmed or whose symptoms increase the index of suspicion that VHF may be confirmed regardless of the initial categorisation.

The need for a lead clinician to have overall responsibility for patients being investigated for VHF is considered essential and arises from lessons learned from the last two incidents of VHF in the UK. That the lead clinician should be a senior member of the medical team is also recommended in the guidance. Responsibility at senior level so that appropriate patient care and infection control arrangements can be implemented and assured is paramount, as patients with VHFs can deteriorate rapidly and can do so whilst initial tests results are awaited. Specifying the specialty of the lead clinician was considered inappropriate as operational arrangements vary between Trusts.

#### *Care in the High Security Infectious Disease Units*

The guidance introduces for the first time the option to care for a patient with high possibility of or confirmed VHF in a high security infectious disease unit without isolating them within a Trexlar isolator, subject to enhanced staff protection measures being applied and subject to clinical need. New in this guidance is acknowledgement that in certain exceptional circumstances, the condition of a patient may be such that transfer is not feasible due to its likely adverse effect upon the patient, and guidance is given as to how risks to staff must be minimised in these circumstances. However, transfer to an HSIDU remains the recommended action for those with confirmed VHF or whose condition has raised the index of suspicion.

#### *Diagnostic testing*

Improvements in diagnostic testing and better understanding of disease transmission risks has been reflected in the guidance on the handling and testing of patient samples whilst awaiting a definitive diagnosis. For those in the lower category of 'possibility of VHF' samples can be handled using standard procedures and practices at containment level 2. Where possible these should be carried out in closed system analysers. Where there is an increased risk from patients categorised as 'high possibility of VHF', sample handling can still be done locally at laboratory containment level 2 providing enhanced precautions are taken as set out in the guidance. Samples from those with confirmed VHF must be handled at containment level 3 and specific controls must be in place as set out in the guidance.

#### **Conclusion**

VHFs are rare in the UK and clinicians are not familiar with their recognition or testing protocols and every incident creates anxiety amongst health care staff and laboratory workers alike. VHFs demand specialist diagnosis and handling if exposure to healthcare workers is to be controlled. Revised guidance is long overdue and clinicians have responded favourably. Their suggested

amendments for improvement and those of ACDP members from past discussions have been incorporated into this draft.