



**Canadian  
Blood  
Services**

BLOOD  
PLASMA  
STEM CELLS  
ORGANS  
& TISSUES

# Surveillance Report

## 2018



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## Executive Summary

We are pleased to present the seventh annual report describing transmissible blood-borne infection surveillance. High quality and timely surveillance is central to the safety of the blood supply. This includes monitoring of transmissible disease markers that the blood is tested for (including bacteria) and investigation of any reports of possible transfusion transmission, as well as a horizon scan for any new pathogens that may pose a risk.

### Infectious Risk Monitoring

The most up-to-date tests for pathogens are used to identify infectious donations and prevent their release for patient use. In 2018, transmissible disease rates per 100,000 donations continued to be very low: HIV 0.1, hepatitis C 6.1, hepatitis B 6.6, HTLV 1.3 and syphilis 3.8. Selective testing of donors at risk of Chagas' disease identified 3 positive donations, and there were 42 donations positive for West Nile Virus. Residual risk estimates of a potentially infectious donation from a unit of blood are very low at 1 in 12.9 million donations for HIV, 1 in 27.1 million donations for HCV and 1 in 1.4 million donations for HBV. Lookback and traceback investigations did not identify any transfusion transmitted infections. Bacterial growth was identified in 171 platelet products. Of 532 potential peripheral stem cell or bone marrow donors tested, 6 (1.1%) were positive for antibody to hepatitis B core antigen. Of 522 samples from mothers donating stem cells collected from the umbilical cord and placenta (called "cord blood") after their babies were born, 1 (0.2%) was positive for hepatitis C.

Horizon scanning for emerging pathogens monitors potential threats to safety. Risk of a tick-borne disease, babesiosis, continues to be monitored. The parasite (*Babesia microti*) that causes babesiosis appears to be in the early stages of becoming established in a few places in Canada, especially in Manitoba. Travelers and former residents from malaria risk areas are temporarily deferred for malaria risk. In addition, a 3 week deferral for any travel outside Canada, the USA and Europe reduces risk from short term travel related infections, such as Zika virus. No new risks from travel related infections were identified this year.

### Non-infectious monitoring

Giving blood is very safe, and serious reactions in donors are quite rare. However, iron depletion is relatively common in female donors and people who donate frequently. Iron stores are not currently being measured in donors. However, iron deficiency can progress to a drop in donor hemoglobin, and donors may then fail their pre-donation hemoglobin screen. In order to help

prevent iron deficiency, in 2017 the waiting time between whole blood donations for females was increased from 56 days to 84 days, and the minimum hemoglobin for males was increased from 125 g/L to 130 g/L. This reduced the low hemoglobin deferral rate overall, as deferrals in females decreased substantially from 13.5% to 7.8% of donation attempts, while the increase in deferrals in males was smaller, from 1.4% to 2.3, now 1.7%.

This report features a new section on Diagnostic Services Laboratories at Canadian Blood Services. These laboratories provide patient testing for some pregnant women and for some high-risk patients receiving blood transfusions. In 2018 1,285 red blood cell antibodies were identified in pregnant women that could put their fetus at risk of hemolytic disease on the fetus/newborn and 1,013 rare red cell antibodies were identified in patients who may need special matching for transfusion.

# 1. Introduction

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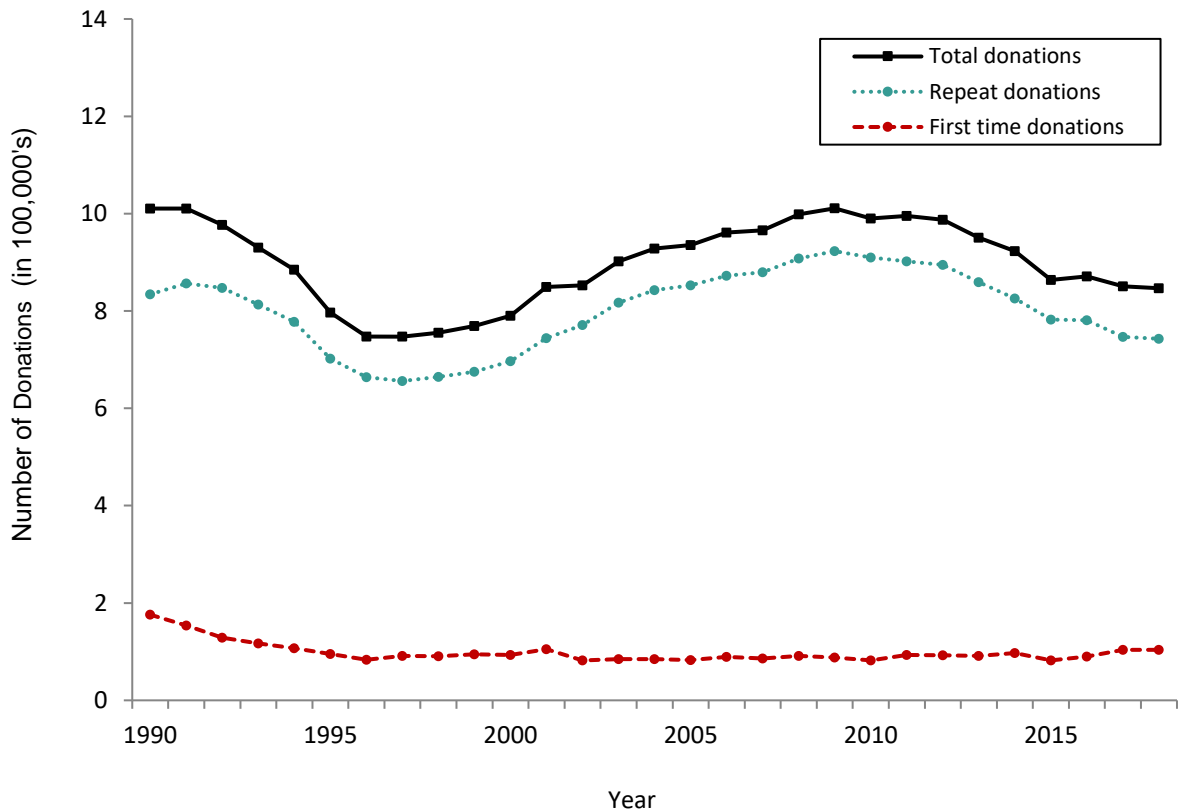
Safety of the blood supply from pathogens involves a multifaceted approach. Donor education materials on the internet and required reading just before donating explain risk factors for transmissible infections and who should not donate. Before donating blood, everyone must complete a health history questionnaire which includes questions about specific risk factors for transmissible infections. This is followed by an interview with trained staff to decide if the person is eligible to donate blood. All donations are tested for markers of transfusion transmissible agents and are destroyed if positive. These include HIV (human immunodeficiency virus or the AIDS virus), hepatitis B (HBV) and hepatitis C (HCV), human T-cell lymphotropic virus (HTLV) (a rare cause of leukemia) and syphilis. West Nile virus (WNV) testing is done during the at-risk period of the year (spring, summer and fall) and in risk-travelers during the winter season. In addition, donors at risk of Chagas' disease (which comes from the bite of an insect in Latin America) are tested, and all platelet products are tested for bacteria.

Surveillance includes monitoring of transmissible infection testing in donors, investigation of possible transfusion transmitted infections in recipients and horizon scanning for new, emerging pathogens. Monitoring the safety of donors is also essential. Although surveillance is conducted in "real time" over each year, final verification steps generally impose a short delay in producing a final report. This report describes Canadian Blood Services' approach to surveillance of transmissible blood-borne infection surveillance and donor safety, as well as data for the calendar year of 2018.

## 2. Blood Donor Surveillance

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The number of allogeneic blood donations (whole blood and platelet and plasma apheresis) from first time and repeat donors are shown in Figure 1. The majority of donations are from repeat donors (87.7%) with 12.3% of donations from new donors.



**Figure 1** Donations in all Canadian Blood Services Regions, 1990-2018

### ***The “Classical” Pathogens***

Details of screening tests used, and dates of implementation are shown in Appendix 1. In Table 1 the numbers of positive donations and the rates of positive tests per 100,000 donations are shown for 2018 by demographic groups. All transmissible infection positive donations occurred in whole blood donations (none in apheresis donations). The rate per 100,000 donations has decreased for most markers and the rate for repeat donations is extremely low (see Appendix 2). When a transmissible infection is detected, it is most often in a first-time donor as these donors have not been tested previously and may have acquired the infection at any time in their lives. Importantly, although the proportion of first-time donors has increased in recent years, there has been no increase in infectious markers.

**Table 1.** Confirmed positive donations and prevalence rates per 100,000 donations in 2018

Characteristic	Number of Donations	Percent of Donations	HIV		HCV		HBV		HTLV		Syphilis	
			Pos	Rate	Pos	Rate	Pos	Rate	Pos	Rate	Pos	Rate
<b>Donor status</b>												
First time	103,866	12.3	0	-	51	49.1	47	45.3	11	10.6	18	17.3
Repeat	742,828	87.7	1	0.1	1	0.1	9	1.2	0	-	14	1.9
<b>Sex</b>												
Female	362,473	42.8	1	0.3	23	6.4	12	3.3	9	2.5	13	3.6
Male	484,221	57.2	0	-	29	6.0	44	9.1	2	0.4	19	3.9
<b>Age</b>												
17-29	186,878	22.1	1	0.5	6	3.2	19	10.2	2	1.1	8	4.3
30-39	149,059	17.6	0	-	8	5.4	6	4.0	0	-	7	4.7
40-49	136,600	16.1	0	-	7	5.1	14	10.3	3	2.2	8	5.9
50+	374,157	44.2	0	-	31	8.3	17	4.5	6	1.6	9	2.4
<b>Total</b>	<b>846,694</b>	<b>100</b>	<b>1</b>	<b>0.1</b>	<b>52</b>	<b>6.1</b>	<b>56</b>	<b>6.6</b>	<b>11</b>	<b>1.3</b>	<b>32</b>	<b>3.8</b>

All transmissible infection positive donations are destroyed and will never be given to a patient. The main source of risk is when a blood donor acquired the infection too recently to be detected by testing. This is called the “window period” of infection. With current testing the window period is very short. For HIV and HCV an infection would be detected within 1 to 2 weeks of a donor being infected, and for HBV within one month. The residual risk of infection is the estimated risk of a potentially infectious donation being given during the “window period”. These estimates were revised in up to 2018 as shown in Table 2. The risk is currently extremely low, but of course it can never be zero.

**Table 2.** Estimated residual risk of HIV, HCV and HBV

HIV	HCV	HBV
1 in 12.9 million donations	1 in 27.1 million donations	1 in 1.4 million donations

### ***Risk Factors***

Risk factor interviews are carried out with donors who test positive for transmissible infections. The main risk factors are shown in Table 3. HIV infections are very rare in donors; therefore, it is difficult to generalize the risk factors. It should be noted that participation is voluntary and therefore there are only data for some donors, and that for many donors no risk factors were identified.

**Table 3.** Risk factors for infectious disease in blood donors

Infection	Risk Factor
HIV	Heterosexual risks Male to male sex
HCV	History of intravenous drug use History of blood transfusion (prior to testing) Been in prison, born in Africa or Asia
HBV	Born in Africa or Asia
HTLV	Born overseas (especially Caribbean) History of other sexually transmitted disease History of blood transfusion
Syphilis	Previous history of syphilis

Note: Not all donors are interviewed, and many do not disclose any risk factors

### ***Chagas Disease (Trypanosoma cruzi)***

Chagas disease is caused by infection with a parasite called *Trypanosoma cruzi* (*T. cruzi*). People can become infected with it after being bitten by an insect in parts of Mexico, Central and South America. The *T. cruzi* parasite can also be passed on from mother to child during pregnancy and by blood transfusion. In 2018, there were 20,165 donations from donors with risk factors, and 3 had a positive test for *T. cruzi* antibody.



## ***West Nile Virus***

West Nile virus is a mosquito borne virus that has been present in North America since 1999 (in Canada since 2002). Although symptoms can be severe, they are usually mild and most people are not aware of their infection. During spring, summer and fall, donations are routinely tested in a mini-pool of 6 donations. However, to further reduce the risk, an algorithm is applied to identify all donations from areas where West Nile virus is active and these are tested as single donations. In 2018, 422,043 donations were tested over the spring/summer/fall when all donations were tested and 42 donations were positive. They were identified from July to October in Ontario, Manitoba, Saskatchewan and Alberta. These correspond with the areas where community cases were reported. Over the winter, 67,326 donations were tested and none were positive.

## **3. Surveillance for Emerging Pathogens**

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A horizon scan of potentially blood borne infections in the general community ensures rapid revision of donor policies to maintain safety. Even before a new infectious disease is reported in Canada, we are aware of emerging infectious agents by monitoring outbreaks in other parts of the world. International travel is commonplace and infections can rapidly enter from other countries. To ensure that potential risks are identified, Canadian Blood Services needs to be connected with the latest infectious disease information at all times. Canadian Blood Services medical and scientific staff participate in public health and infectious disease professional organizations and monitor web sites and journals where new information is posted. Canadian Blood Services maintains a plan to address pandemic influenza, which can be adapted to deal with other large outbreaks affecting donors and staff. When appropriate the Alliance of Blood Operators (ABO) Risk Based Decision Making Framework can be used. This ensures that relevant assessments including infection risk to recipients, operational impact of strategies, stakeholder input and health economics are considered.

## **Potential infectious risks within Canada**

Ongoing surveillance of a range of infectious agents that could emerge as a threat within Canada are being monitored. Two that prompted additional studies to better assess the risk are described here.

### ***Babesiosis***

Babesiosis comes from the bite of the black-legged tick (*Ixodes scapularis*). Usually it causes mild flu-like symptoms, and many people are not even aware that they have had it. However, it can also be transmitted by blood transfusion, and infection in blood recipients can result in severe illness or death. To date babesiosis cases in the general population have been reported mainly in the North Eastern and Upper Midwest parts of the United States; where more than 1,500 cases per year are reported. Cumulatively more than 200 infections in the United States are believed to have been acquired from a transfusion. In Canada the parasite is found in small numbers of ticks, but only one human case in the community from tick exposure has been reported. A 2013 study at Canadian Blood Services and Héma-Québec tested 13,993 blood donations and none were positive. Ongoing public health surveillance of ticks suggests no increase in risk, but a donor study was carried out in 2018 involving more donors. Results are being analyzed.

### ***Hepatitis E (HEV)***

Hepatitis E is common in developing countries where it is spread through contaminated food and water. People can also be infected from eating undercooked pork. Similar to hepatitis A, healthy people often do not get very sick, generally clear the infection and never know they had it. However, blood recipients could become very ill. A 2013 study at Canadian Blood Services and Héma-Québec showed that 5.1% of donations were positive for antibody (indicating a previous infection with Hepatitis E) but none were positive for the virus. In 2015 a larger study (over 50,000 donations) with a more sensitive test identified 1 in 4,615 HEV positive donations. However, most were later stage infections with low concentrations of virus thus less likely to be infectious. The risk is lower than in some countries in Europe that have testing in place. The ABO Risk Based Decision Making Framework is being used to consider strategies to address risk.

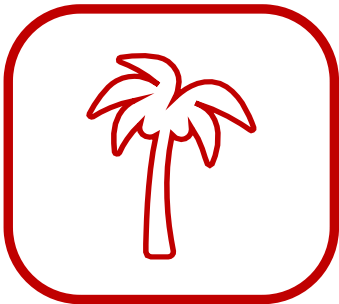
## **Travel related infections**

With more and more people travelling, there are risks that they may return with infections that could be transmitted by blood (see Figure 2). Most are only a risk for a period of time after returning. Malaria risk is present in parts of the Caribbean, Mexico, Central and South America, Asia and Africa. Donors are deferred after travel to risk areas for 12 months, enough time to develop symptoms. Former residents of endemic areas are deferred for 3 years because there is a chance they may be infected longer without symptoms. Other tropical mosquito-borne infections such as dengue virus have long been present in sunny destinations frequented by Canadians, but in recent years there have been outbreaks of others such as Chikungunya virus and Zika virus not previously seen in the Caribbean, Mexico, Central and South America. Risk to the blood supply was determined to be very low based on quantitative risk assessment. However, to address future travel risks as of 2016 Canadian Blood Services defers all donors who have travelled anywhere outside of Canada, the USA or continental Europe for 3 weeks after travel. Other travel risks such as for variant-Creutzfeldt Jakob disease (vCJD) have longer deferrals. vCJD is acquired from eating infected meat (Mad Cow Disease) in England and other European countries. Donors are deferred for time spent in those countries while infected meat may have been available. Infectious risks in other countries are closely monitored to decide if further action is needed.

# Travel Deferrals



Protecting the blood from insect and food borne infections



**Dengue**  
**Chikungunya**  
**Zika**

**3 week deferral**

Any travel outside  
USA or Canada



**Malaria**

**1 year deferral**

Travel to risk area

**3 year deferral**

Living in risk area



**Variant**  
**Creutzfeldt**  
**Jakob Disease**

**Indefinite deferral**

3 months UK or France

1980 -1996

5 years in Western

Europe 1980-2007

6 months Saudi Arabia

1980-1996

**Figure 2** Key travel deferrals in place to reduce risk of transmissible infections.

## 4. Bacteria

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Bacteria in blood products usually come from the skin of donors during their blood donation, although occasionally they may come from the donor's bloodstream. The amount of bacteria is usually very low, but because platelet products are stored at room temperature the bacteria can multiply to reach high concentrations and then pose a serious risk to the recipient. Canadian Blood Services tests all apheresis and pooled platelet products for bacteria using the BacT/ALERT System in which a sample from the product is inoculated into an aerobic (presence of oxygen) culture bottle and an anaerobic (absence of oxygen) culture bottle and monitored for growth for the full 7 days of shelf life of the product. The product is recalled and returned to Canadian Blood Services any bacterial growth is detected and the product is still available (i.e., has not been transfused or discarded). In 2018, 110,174 platelet products (15,565 apheresis and 94,609 pooled products) were tested, of which 137 apheresis and 282 pooled products had initial positive results for bacterial growth in the culture bottles. From these, 3 and 73 cultures were confirmed as true bacterial contaminations, for apheresis and pooled products, respectively. In addition, 19 apheresis and 76 pooled products with initial positive results were not confirmed as they were issued and/or transfused. This represents 171 products in total (15.5 per 10,000) with a chance of bacterial contamination with current testing, including both true positives and suspected positives.

## 5. Donor Eligibility Criterion for Male to Male Sex

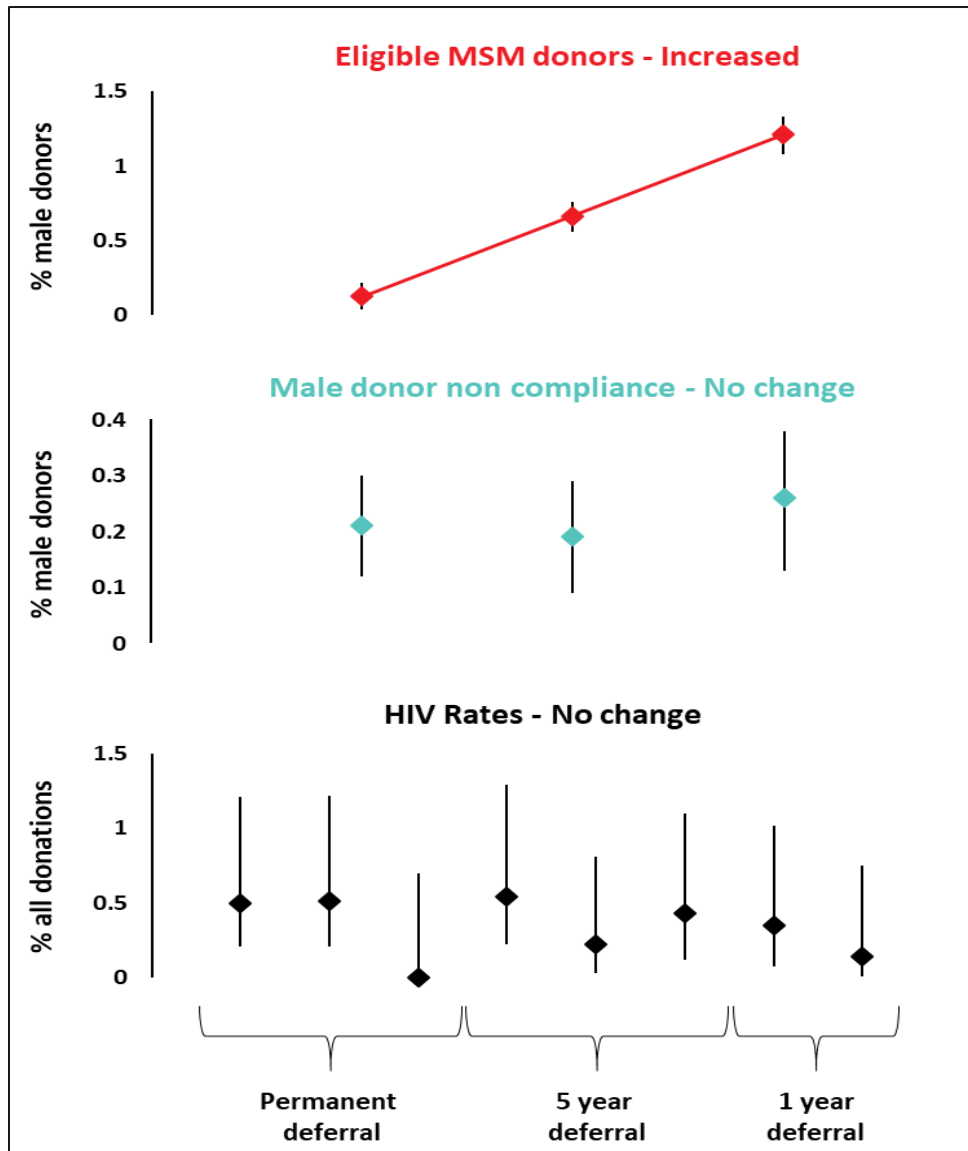
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Since the 1980's men who have had sex with another man even once since 1977 were not eligible to donate blood to reduce the risk of AIDS/HIV transmission. With much improved donor testing and surveillance for emerging pathogens the deferral period has been gradually reduced, moving to 5 years in 2013 and to 1 year in 2016. This allowed more MSM to donate blood while HIV rates in blood donors have not increased, and donor compliance was not adversely affected (See Figure 3). Other countries such as the USA, France and Australia have also switched to a 1 year deferral. In England their 1 year deferral was recently reduced to 3 months. Canadian Blood Services and Héma-Québec submitted applications to Health

Canada in December 2018 to reduce the deferral period for MSM to 3 months. A decision is expected in the first half of 2019.

Canadian Blood Services is committed to ongoing revision of this policy, ideally to find a way to more finely define donor sexual risk rather than deferring all sexually active MSM. In January of 2017 Canadian Blood Services and Héma-Québec hosted a meeting which included Canadian researchers in gay men's health, regulatory staff (Health Canada and the USA Food and Drug Administration), stakeholders and international experts. The attendees brainstormed to identify the key areas of research needed to assess the safety of potential changes to the deferral. Canadian Blood Services and Héma-Québec then launched a competitive grant program to allocate funding provided by Health Canada to Canadian researchers. To date, 14 research projects are being funded in this grant program.

<https://blood.ca/en/research/our-funded-research-projects?combine=msm>



**Figure 3.** Increased eligible MSM donors but no change in non-compliance with the deferral or HIV rates as the duration of deferral periods was decreased.

## 6. Lookback/Traceback

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All cases of potential transfusion transmission of disease are investigated. When a donor tests positive for a transmissible disease, or if the donor reports a transfusion transmissible disease after donating (even if it is not one that would normally be tested for) a lookback file is opened. All previous donations are identified, and hospitals are asked to contact the

recipients of these donations to arrange testing. A traceback is initiated when a recipient is found to have a transmissible disease and it is queried as to whether it could have been from their blood transfusion. All blood products that the recipient received are identified by the hospital, and Canadian Blood Services attempts to contact the donors of these products to arrange testing.

There were 64 lookback cases for repeat donations in 2018 (15 for donors that tested positive with in-house testing, 49 from external testing or public health notification and 0 identified during traceback investigation). Of these 48 cases were closed (all recipients that could be contacted were tested) which included 0 HIV, 39 HCV, and 6 HBV, 0 HTLV and 1 WNV, 1 Babesia, 1 Coxiella burnetii, 0 Chagas cases. The remaining 16 cases were still open. There were 22 open cases from previous years that were closed in 2018. No closed cases were associated with transfusion transmission. There were 57 traceback cases opened in 2018 (9 HIV, 46 HCV, 2 HBV, and 0 HTLV). Of these, 42 were closed (all donors that could be contacted were tested), and 15 remain open. There were also 11 cases from previous years closed. There were no closed cases associated with transfusion transmission.

## 7. Blood Stem Cells

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Blood stem cells can multiply to renew themselves; the new cells develop into blood cells such as red cells, white cells and platelets. In adults, they are found mainly in the marrow of large bones, with a few cells in the bloodstream. The cord blood of newborn babies, taken after birth from the umbilical cord and placenta after the delivery of a healthy baby, is also very rich in stem cells. Blood stem cells are very important in treating various types of diseases such as leukemia, lymphoma and multiple myeloma. Blood stem cells can be obtained from the bone marrow, from circulating blood (called peripheral blood stem cells) or from the umbilical cord (cord blood) after a baby is born. Canadian Blood Services has a coordinated national stem cell program which includes adult registrants and banked cord blood units. Infectious disease testing for stem cells includes the same markers tested for whole blood donations.

### ***Canadian Blood Services' Stem Cell Registry***

Canadian Blood Services' Stem Cell registry is a registry of Canadians who have volunteered to donate either bone marrow or peripheral blood stem cells should a recipient



need it at some time in the future. Potential registrants complete a questionnaire which includes risk factors for transmissible infections and are tested for their Human Leukocyte Antigen (HLA) profile. In 2018 there were about 440,000 registrants in the registry. In total, 532 registrants were identified as potential matches for recipients and had additional testing. Of these six (1.1%) were reactive for antibody to hepatitis B core antigen (anti-HBc). For comparison, about 1% of first-time whole blood donors are reactive for this marker. All tested registrants had negative results for all other infectious disease markers.

### ***Canadian Blood Services' Cord Blood Bank***

Canadian Blood Services' Cord Blood Bank collected cord blood at four sites in Canada in 2018. Participating mothers at these hospitals who volunteer to donate their baby's cord blood complete a questionnaire about medical conditions that could be passed on to a recipient, as well as risk factors for transmissible infections. If the donation is suitable for transplantation (i.e., has enough stem cells) with negative results for all infections, the cells are frozen and stored until a recipient needs them. In 2018, there were 522 blood samples from mothers tested of whom one (0.19%) was positive for HCV.

## **8. Donor Safety**

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### ***Donor Reactions***

Canadian Blood Services takes many precautions to make sure that giving blood is safe for donors. These include a health screening questionnaire and a hemoglobin fingerstick screen, as well as providing refreshments and monitoring the donor after donating. Most donors do not have any problems during or after their donation, but it is important to keep track of any incidents that happen so that donor care can be improved.

Definitions of reactions are shown in Table 4. Reaction rates per 10,000 whole blood donations are shown in Figure 4. People more likely to experience a reaction are first time donors, young donors (17-25 years old) and female donors. The reaction reporting system is oriented towards capturing moderate and severe reactions. Most reactions are mild, such as feeling faint or bruising at the needle site, but these are only recorded if mentioned by the donor at some point after donation. Note that it is difficult to know if cardiovascular events

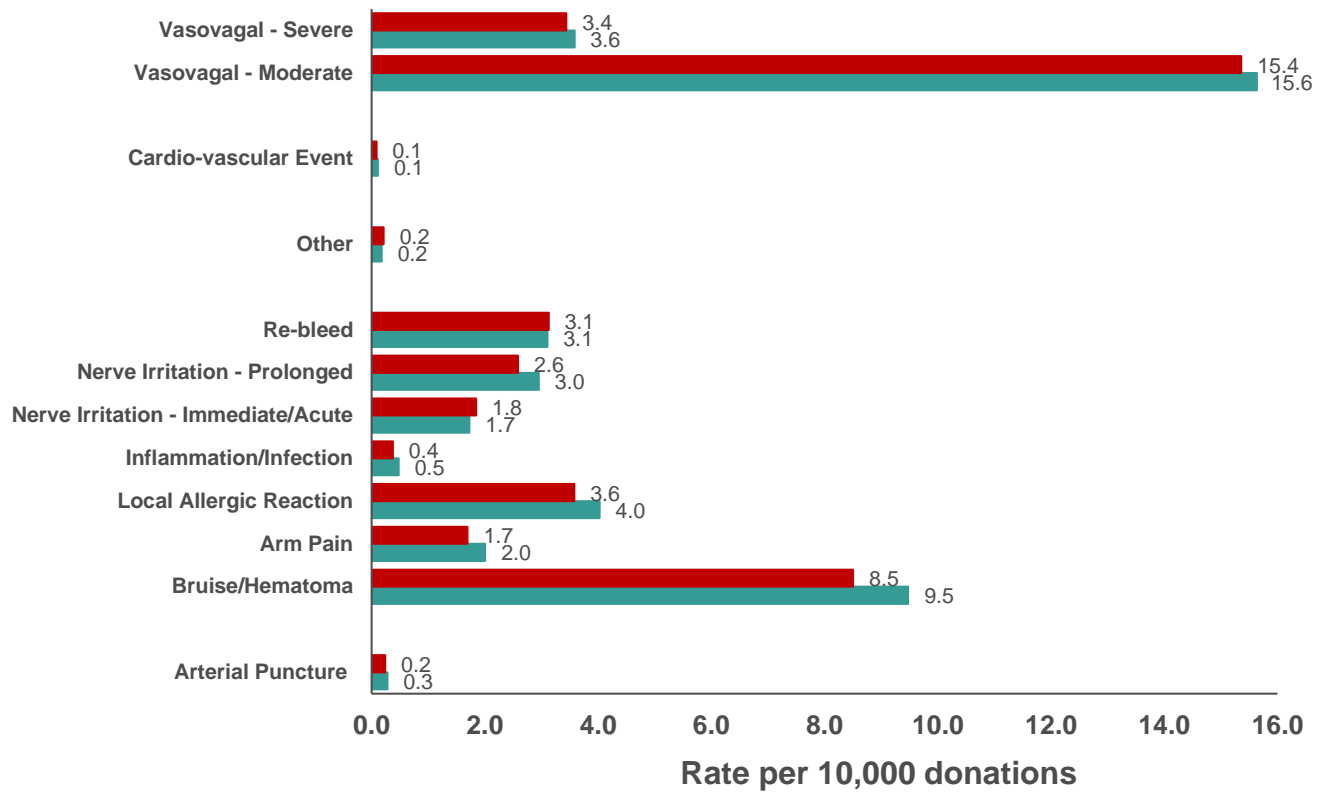
that happen shortly after donation are in any way related to donation, or simply happened by chance in the 24 hours after donation.

A further breakdown of fainting reactions (both moderate and severe) in whole blood donors by sex and donation history is provided in Table 5. These are similar to those reported in 2016 ( $p=0.5$ ).

Serious reactions that can lead to physical injury or prolonged symptoms are rare but when they happen usually involve first time donors and female donors. The rates of injury (most commonly falls with cuts) with fainting are seen in Table 5. Drinking fluids reduces the chance of feeling faint. All donors (whole blood and apheresis) are encouraged to drink fluids before and after donation. In 2019 all donors will also be provided with salty snacks and instructions to do muscle tension exercises to further reduce the risk of feeling faint.

**Table 4.** Reaction and definitions

<b>Reaction</b>	<b>Definition</b>
Vasovagal	Donor loses consciousness (faint reactions)
Moderate	Unconscious less than 60 seconds and no complications
Severe	Unconscious more than 60 seconds or complications
Major Cardiovascular Event	Chest pain or heart attack within 24 hours of blood donation, may or may not be related to donation
Re-bleed	The phlebotomy site starts to bleed after donation
Nerve Irritation	Needle irritation or injury of a nerve during phlebotomy. Usually described as sharpshooting pain, arm tingling or numbness
Inflammation/Infection	Redness or infection at the needle site, usually seen several days after donating
Local Allergic Reaction	Rash from skin cleaning solution or dressing, with raised vesicles on the skin
Arm Pain	Usually due to blood pressure cuff, tourniquet or arm position
Bruise/Hematoma	Temporary dark colour of the skin due to blood leakage from blood vessel at time of phlebotomy
Arterial Puncture	Needle inserted in an artery instead of a vein



**Figure 4.** Reaction rates per 10,000 whole blood donations in 2018 (red) and 2017 (green)

**Table 5.** 2018 Fainting reactions (per 10,000 collections)

Donation Status	Moderate & Severe (all)		Associated with injury	
	Male	Female	Male	Female
<b>First Time</b>	59.5	83.0	1.4	4.2
<b>Repeat</b>	6.3	19.0	0.3	1.1

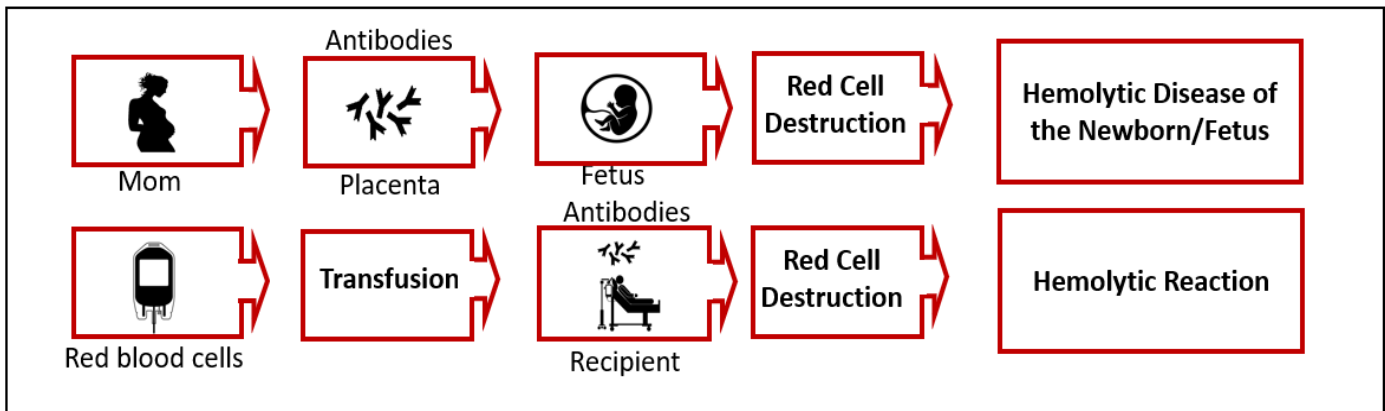
\*all comparisons are statistically significant (p<0.05)

## ***Donor Hemoglobin and Iron***

The most common reason for a donor deferral at the collection site is a failed hemoglobin fingerstick screen. Low hemoglobin is often related to low iron stores. Iron is needed to make hemoglobin which carries oxygen in red blood cells. Studies at Canadian Blood Services showed that iron stores are often lower in females and are further reduced by frequent donation in both females and males. Males with borderline hemoglobin are also more likely to have lower iron stores. To reduce the chance of developing iron deficiency, the minimum wait time between whole blood donations for females was increased from 56 days to 84 days in 2017. This longer interdonation period allows females more time to build back their iron stores and return to their baseline hemoglobin levels. Hemoglobin deferral rates have gradually decreased in female donors from about 13.5% of donation attempts to 7.8% ( $p < 0.001$ ). In 2017 the minimum hemoglobin for male donors was increased from 125 to 130 g/L to align with a healthy hemoglobin in males which is higher than for females. As a result, the hemoglobin deferral rate in males initially increased from 1.4% to 2.3% but has now dropped back to 1.7%. There was an overall net decrease in hemoglobin deferrals due to the large decrease in females. Importantly, mean hemoglobin levels have increased steadily over two years from 149.9 to 152.9 g/L in males and 136.2 to 138.0 g/L in females.

Information about [iron](#) and the [safety](#) of blood donation can be found at [www.blood.ca](http://www.blood.ca) as well as in the '[What you must know to give blood](#)' pamphlet provided to all donors prior to every donation.

## 9. Diagnostic Services

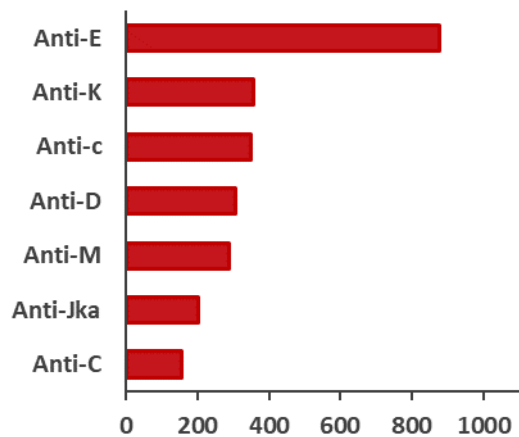


The Diagnostics Services Laboratories provide patient testing, mainly for pregnant women (Perinatal Laboratories) and patients receiving blood transfusions (Crossmatch/Reference Laboratories).

### **Perinatal Laboratories**

The Perinatal Laboratories provide testing of pregnant women for blood group and antibodies to red blood cells. Some antibodies can cause hemolytic disease of the fetus/newborn. The goal is to 1) identify Rh negative pregnant women and recommend treatment to prevent developing anti-D antibodies, and 2) identify pregnant women with risky antibodies to monitor their pregnancy and treat as needed. Testing of fathers, newborns and fetuses is also sometimes done. In 2018 1,285 women had red blood cell antibodies; the most often occurring ones that could put their baby at risk are shown in Figure 5.

Maternal	97.7%
Paternal	1.0%
Cord	1.3%
199,863 Samples Tested	



**Figure 5** Number of clinically significant perinatal antibodies

### Crossmatch/Reference Laboratories

The reference laboratories provide testing of patients for blood groups which must match the donor blood to be transfused. They also carry out antibody investigations for patients who may have unusual red blood cell antibodies and need special matching of blood for transfusion. Figure 6 shows the frequency of different antibodies in pre-transfusion patients. Patients who have rare antibodies/antigens may be difficult to match for transfusion. The Winnipeg laboratory also provides crossmatch services for patients in Manitoba.

For more detail see <https://blood.ca/en/hospital-services/laboratory-services/surveys>

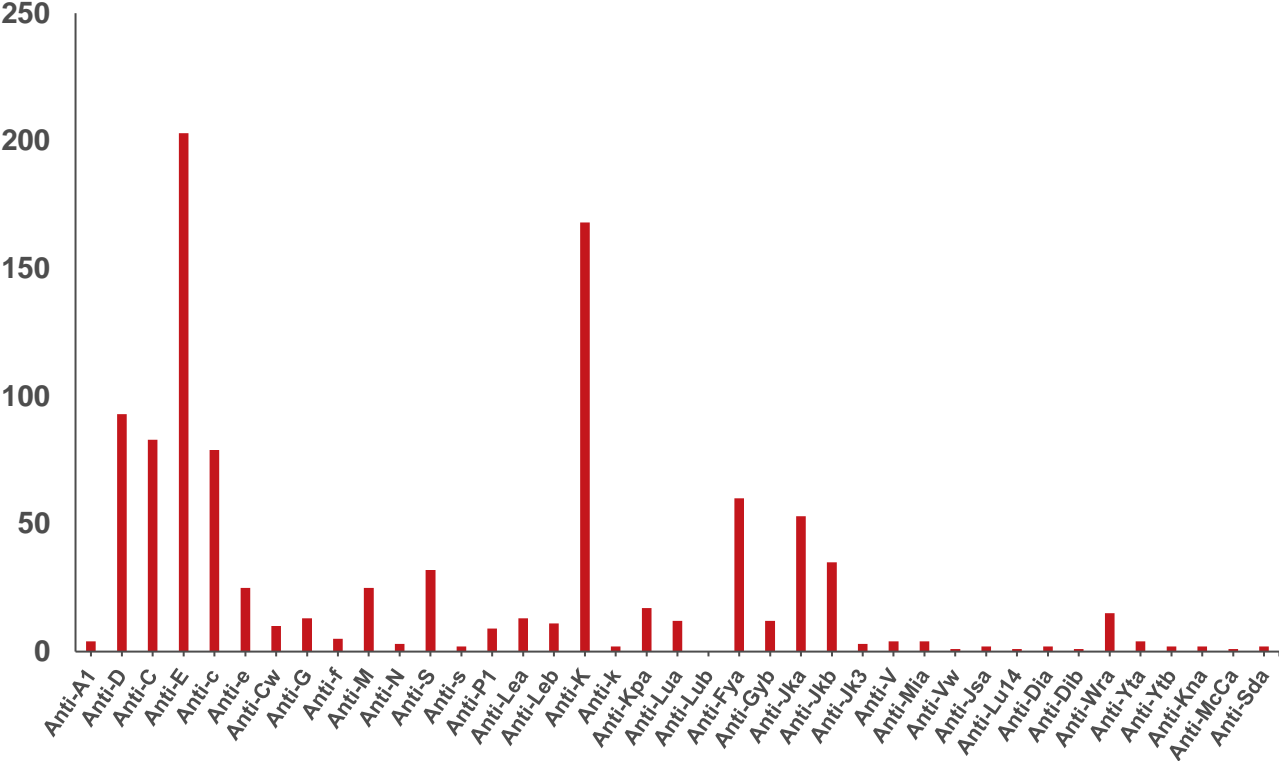


Figure 6. Number of reference antibodies, 2018

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# APPENDIX I

## Implementation Dates of Testing

	Marker	Implementation Date*
1	<b>Syphilis</b>	1949
2	<b>HBV (Hepatitis B Virus)</b>	
	HBsAg	1972
	Anti-HBc	2005
	HBV NAT	2011
3	<b>HIV (Human Immunodeficiency Virus)</b>	
	Anti-HIV-1 EIA (enzyme-linked immunosorbent assay)	1985
	Anti-HIV-1/2 EIA	1992
	HIV-1 p24 antigen	1996 (discontinued in 2003)
	HIV-1 NAT	2001
	Anti-HIV-1/2 (including HIV-1 subtype O) EIA	2003
4	<b>HTLV (Human T-Lymphotropic Virus)</b>	
	Anti-HTLV-I	1990
	Anti-HTLV-I/II	1998
5	<b>HCV (Hepatitis C Virus)</b>	
	Anti-HCV EIA/ELISA	1990
	HCV NAT	1999
6	<b>WNV (West Nile Virus)</b>	
	WNV NAT	2003
7	<b>Chagas' disease (<i>Trypanosoma cruzi</i>) selective testing</b>	2010
8	<b>Bacteria</b>	
	BacT Alert	2004
	BacT Alert modified for 7 day platelets	2017

\*These are the dates that testing for the marker began. Tests have been upgraded as new versions of the test became available.

## APPENDIX II Rate of HIV, HCV, HBV, HTLV and syphilis in first-time and repeat donations (note that these graphs have different scales on the y-axis).

