醫院管理局
HOSPITAL AUTHORITY

(Press Release)

Thursday, 22 December 2016

Attention News Editors:

The spokesperson of Queen Mary Hospital (QMH) made the following announcement today (22 December) regarding a case of hepatitis C infection:

A 94-year-old female patient was admitted to Orthopaedics and Traumatology (O&T) Ward via Accident and Emergency Department of QMH between 16 and 22 July 2016 for her back pain problem. During her stay in ward, the patient showed liver function derangement and was arranged viral hepatitis testing. The patient was later transferred to Tung Wah Group of Hospitals Fung Yiu King Hospital for rehabilitation. Test result on 3 August was indeterminate to Hepatitis C antibody and the patient discharged on 5 August.

Upon discharge, the patient continued her follow-up at the Medical Specialist Out-patient Clinic with stable condition. The patient was admitted to Medical Ward of QMH again, via Accident and Emergency Department on 30 November. Attending physician, when reviewing the case, found that the second hepatitis testing was in fact arranged on 24 August and the test result available on 2 September was positive to Hepatitis C antibody. The case was reported accordingly to the hospital and the Department of Health on 5 December and 13 December respectively.

The hospital was deeply concerned towards the incident and had arranged hospital microbiologist and infection control experts to assess the case. Since the patient did not have previous record of hepatitis C infection, the expert group was concerned about the possibility of hospital-acquired infection. However, as the patient had also stayed in the community for a period of time upon discharge, the expert group could neither rule out the possibility of community-acquired infection

Since hepatitis C is transmitted mainly through blood contact, the preliminary focus of investigation is on blood product and blood transmission procedure. The expert group opined that compliance with stringent guidelines was required in the production of blood products, hence, the risk of contamination was relatively low. At the same time, the Hong Kong Red Cross Blood Transfusion Service (BTS) had followed up with the 25 blood donors whose blood had been transfused to the patient. So far, 23 donors has confirmed negative to hepatitis C while the test for the remaining two donors are being arranged. At present, blood collected from eligible donors has to go through stringent

Queen Mary Hospital
Hong Kong West Cluster
Hospital Authority
102 Pok Fu Lam Road
Hong Kong
Tel: (852) 2255 3838
Fax: (852) 2817 5496

瑪麗醫院
港島西醫院聯網
醫院管理局
香港薄扶林道 102 號
電話：(852) 2255 3838
傳真：(852) 2817 5496

infectious disease screening before it can be used for clinical blood transfusion. This includes hepatitis B antigen and DNA, hepatitis C antibodies and RNA, HIV antibodies and RNA, T-lymphotropic virus antibodies and syphilis antibodies.

As a precautionary measure, QMH had started contacting 14 patients who had stayed in the same cubicle with the concerned patient to explain to them the incident while arranging viral testing and health surveillance. This follow-up arrangement would be instrumental to help identify the possible cause of infection and to ascertain the appropriateness of infection control measures now being in place.

The patient is currently staying in QMH with stable condition.

The hospital has reported the case to HAHO through the Advance Incident Reporting System and the Centre for Health Protection. The hospital is also concerned about the cause of delayed notification of hepatitis C infection according to stipulated guideline. Healthcare staff are reminded again on the requirement of timely reporting and to ensure clinical treatment are provided as appropriate.

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Enquiry: 7306 9243

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