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## Policy

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### Purpose

This document outlines the procedures required for managing known or suspected CJD patients who undergo invasive procedures within Canterbury District Health Board facilities in order to prevent disease transmission.

(This document excludes reference to risk issues and management of variant CJD (vCJD) where different from CJD – refer point 3 below in general information)

### Policy

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Transmission of Transmissible Spongiform Encephalopathies (TSE's), of which CJD is the main causative agent, shall be prevented through adherence to the procedures outlined in this document

## Scope

All staff involved in the care and management of patients with possible, probable or confirmed CJD

## Associated documents

CDHB documents, e.g.

- Legal and Quality (Volume 2)
  - Management of Healthcare Waste
- [Standard Precautions Policy](#)
- [Decontamination of the Environment](#)
- CHL Mortuary Procedures Manual
- CHL Health & Safety Manual
- Christchurch Hospital - Operating Theatres Procedures Manual
- Sterile Services Department: protocol for management of Instruments & Equipment used in CJD cases
- Sterile Services CJD notification Form

## General Information

Creutzfeldt-Jacob Disease (CJD) is a rare and fatal neuro degenerative disease that is caused by a prion (i.e. an infectious particle smaller than a virus). The potential for transmission is via contaminated instruments or contaminated higher - infectivity tissues. CJD prions are resistant to standard instrument reprocessing and sterilisation procedures.

CJD is a [notifiable disease](#) in New Zealand

Additional information may be found in the following links:

1. [New Zealand Ministry of Health CJD and other spongiform encephalopathies \(2012\)](#)
2. [Australian Government Department of Health CJD Infection Control Guidelines \(2013\)](#)

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The above guidelines excludes reference to vCJD due to a lower risk of incidence of vCJD in Australia.

3. [Government UK \(2015\) Minimise transmission of CJD and vCJD in healthcare settings](#)

If a specific guideline related to a case of vCJD is required, reference to the above UK guidelines is recommended.

## 1 Assessing the Risk

None of the references provide evidence that CJD can be spread through social contact, mother-to-child transmission or blood or blood products. Most infectivity will be concentrated in the central nervous system. There is no evidence of infection via saliva, body secretions or excreta (UK Department of Health 2013).

### 1.1 Risk assessment tools

- Known or predicted infectivity of tissues and fluids
- Patient Risk categories
- Risk assessment matrix

Table 1. Known or predicted infectivity of human body tissue

CJD		
Infectivity category	Tissues	Secretions & Excretions
High-infectivity or medium infectivity	Brain Dura mater Pituitary Gland Spinal cord Posterior eye (includes: posterior hyaloid face; retina; retinal pigment epithelium; choroid; sub-retinal fluid; optic nerve) Cranial or dorsal root ganglia Olfactory epithelium	
Low-infectivity or no detectable infectivity	Cornea Anterior segment of eye Kidney Liver Lung Lymph nodes/spleen/tonsils	CSF Amniotic fluid Breast milk Nasal mucus Saliva Semen

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	Placenta/Uterus Adipose tissue Adrenal gland Blood and blood products Bone and bone marrow Oral tissue (teeth, gingival tissue, dental pulp) Heart muscle Intestine Peripheral nerve Prostate Skeletal muscle Ovaries Testes Thyroid gland	Serous exudate Sweat Tears Urine Faeces
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#### Patient Risk categories

- High-risk – people who represent a definite risk of CJD transmission (refer [Australian Government Guidelines Appendix 1](#)). These patients typically report neurological symptoms and display neurological signs of disease;
- Low-risk – people who represent a potential risk of CJD transmission (refer [Australian Government Guidelines Appendix 2](#)). These patients may report neurological symptoms or be showing neurological signs or may have an identified risk factor.

Table 2 Risk assessment Matrix

Patient risk category	Procedures involving high infectivity or medium-infectivity tissues (see Table 1)	Procedures involving exposure to low or no infectivity tissues (see Table 1)
High risk patient	Use additional procedures	Use routine/standard precautions
Low risk patient	Use additional procedures	Use routine/standard precautions

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See or [page 6, Section 3.2 Australian Government Guidelines](#)) for handling and reprocessing of surgical instruments and diagnostic equipment. Refer also to CDHB Operating Theatre Guidelines and Sterile Services protocols.

## 2 General Management of Patients in Hospital

### 2.1 Patient Management:

- Patients may be nursed using Standard Precautions
- There are no additional requirements for environmental decontamination at ward level
- CJD is a [notifiable disease](#) in New Zealand and must be reported immediately on suspicion to the Medical Officer of Health

### 2.2 Waste Procedures

- With the exception of Operating Theatres and SSD, CJD waste is treated as normal waste and disposed of as per CDHB Waste policy.
- For disposal of CJD waste in theatres refer to Christchurch Hospital - Operating Theatres Procedures Manual

### 2.3 Surgical Procedures

- Infection Prevention & Control, Operating Theatre staff and Sterile Services staff must be advised if surgery is planned on a patient who has or is suspected of having CJD as the case must be managed using additional procedures (refer to Christchurch Hospital - Operating Theatres Procedures Manual).

### 2.4 Dental Procedures

- The risks of transmission of infection from dental instruments is considered low, providing optimal standards of infection prevention & control are maintained.
- Instruments used in routine dental procedures that come in contact with **low-infectivity tissues** (Table 1) in high or low-risk patient categories (Table 2) may be reprocessed using routine procedures.
- Instruments or equipment used in oro-facio-maxillary surgical procedures that come into contact with **high-infectivity tissues** in patients of high or low risk (Table 2) should be reprocessed using additional reprocessing procedures (refer local sterile

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services procedures or [page 6, Section 3.2 Australian Government Guidelines](#)).

- Sterile Services must be notified to enable their CJD protocol to be implemented.

## 2.5 Neurology Services

- Reusable EMG needles, EEG electrodes, sensory testing pins and lumbar puncture needles shall be reprocessed through normal procedures where they do not have contact with high infectivity tissues.
- A single use neurological endoscope should be used where a diagnosis of possible or CJD is unclear.

## 2.6 Endoscopy

- Any endoscope used in a procedure in a high risk-or-low risk patient where high-infectivity tissue has been exposed (e.g. ventriculoscope) should be disposed of or kept exclusively for that patient
- In all other situations, endoscopes may be reprocessed using routine processes
- The advice of the consultant carrying out an endoscopic procedure in the nasal cavity should be sought to determine whether a risk of contamination of the scope with olfactory epithelium can be excluded with confidence (normal nasal endoscopes procedures do not reach the olfactory epithelium). If not, this scope will have to be treated as high risk and should be disposed of or kept exclusively for that patient.

## 2.7 Laboratory Procedures

- In the clinical pathology laboratory, blood, serum and CSF from all patients can be treated according to Standard Precautions. However, in the anatomical / surgical pathology laboratory, appropriate containment and decontamination procedures are necessary when handling brain tissue and other surgical specimens from patients.
- Label all relevant samples and their request forms with “CJD risk sample” and notify the laboratories in advance.
- Refer to the Canterbury Health Laboratories Health & Safety Manual for further detail

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## 2.8 After Death Management

- Deceased patients should be placed inside a body bag before transfer to the mortuary/funeral directors.
- Relatives/friends/carers may wish to view the deceased. Viewing and superficial contact need not be discouraged.
- Normal burial or cremation procedures can take place; no additional special arrangements are required.

Refer to CDHB Mortuary Guidelines for Management of CJD

## 3 Occupational Exposure

There is no evidence of occupational transmission of CJD to a healthcare worker (SHEA 2010). The highest potential risk results from exposure to high infectivity tissues through needlestick injuries with inoculation.

## Measurement or evaluation

A debrief with all key stakeholders will be held to evaluate the policy following presentation of a CJD case

## References

1. [Australia Government Department of health \(2013\) Creutzfeldt-Jacob disease \(CJD\): Infection Control Guidelines](#)
2. [Government UK \(2015\) Minimise transmission risk of CJD and vCJD in healthcare settings Guidelines](#)
3. [New Zealand Ministry of Health CJD and other spongiform encephalopathies \(2012\)](#)
4. [SHEA Guideline \(2010\) Guideline for Disinfection and Sterilization of Prion-Contaminated Medical Instruments](#)
5. [GENCA, Infection Control in Endoscopy](#)
6. [Community & Public Health \(2016\) CJD Spongiform Encephalopathies](#)

<b>Policy Owner</b>	Director of Infection Prevention & Control
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<b>Policy Authoriser</b>	Executive Director of Nursing
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