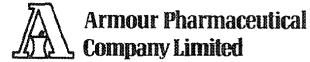


REVION HEALTH CARE (UK) LIMITED



INTER OFFICE MEMORANDUM



CONFIDENTIAL

TO : FILE DATE: April 30, 1985  
FROM : R. B. CHRISTIE REF: RBC/EB/7058  
SUBJECT : VISIT TO DR. F.G.H. HILL, CONSULTANT HAEMATOLOGIST, **P0000038/1**  
BIRMINGHAM CHILDREN'S HOSPITAL - 29TH APRIL, 1985

COPIES TO :  
Mr. P. B. Lloyd  
Mr. C. R. Bishop

The objective of the visit was to discuss Dr. Hill's research on AIDS and Haemophiliacs and his recent Hepatitis B problem.

(1) HEPATITIS CASES

9 children have been shown to be positive for Hepatitis B surface antigen. All are clinically well and one is clearing the antigen. One patient has had only X61611 while the others received both X61611 and X60311. None have had X60311 only. This tends to indicate that X61611 is probably the problem batch.

A further 18 children who have received these batches are Hepatitis B antigen Negative.

Bleeds for latest tests have only just been completed hence results not yet available on up-to-date situation.

Dr. Hill 'phoned the laboratory at East Birmingham Hospital to obtain the results of virology on the two batches under suspicion.

EY RIA neither had Hepatitis B antigen, neither had Hepatitis B core antibody. Both had hepatitis B surface antibody and batch X61611 was higher in titre than X60311.

It is therefore possible that the antibody is neutralizing the antigen and although the vials are infected it is not being detected in the RIA test.

It was agreed that we ought to proceed to the enzyme dissolution test of Dr. Dane (now Dr. Tedder, Middlesex Hospital) to finally confirm. If this is still negative, Dr. Hill thinks that we should finally eliminate all suspicion of infection by injection into a primate. I agreed to follow up these suggestions without delay.

April 30, 1985

VISIT TO DR. F.G.H. HILL

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(2) AIDS RESEARCH

Dr. Hill's original project involving the children exposed to tuberculosis has been written up for publication. He will send me a transcript.

Dr. Hill continues to screen haemophiliac children for HTLV-III antibodies. Just over 50% are positive. The Edinburgh experience indicates that many of those who are sero-negative may have active virus. Until there is a test for HTLV-III antigen we cannot be sure that a negative antibody means free from infection. Dr. Hill suspects that all children who have had a long exposure to concentrate may well be infected!

The development of antibodies appears to correlate with the amount of concentrate treatment received, as do the T4/T8 ratios and lymphocyte changes.

One area of concern is that the sister of one of the HTLV-III positive patients with Hepatitis has also developed both Hepatitis B and a borderline HTLV-III + ve antibody. She is not a needle stick case but does hold her brother's nose when he gets a nose bleed.

Dr. Hill is now testing parents and siblings of haemophilia patients.

A further question associated with the recent hepatitis B outbreak is the possibility that haemophiliacs exposed to HTLV-III lose their immunity to hepatitis virus.

One patient was Hepatitis B core antibody + ve in February 1982, in August 1982 he was NEGATIVE, also in April 1983. The same patient was HTLV-III Negative in June 1983, but in June 1984 he was HTLV-III positive. This possibility is being followed up. If true, it is very worrying, since all immunologists agreed that if a person was Hepatitis B antibody positive he was immune for life.

The Haemophilia Centre is also following up adults who have received concentrate. Of the positive children, 2 have pre-AIDS lymphadenopathy, the remainder are asymptomatic.

One child who has only had Armour Factorate is HTLV-III negative and one child who had N.H.S. material only is negative. The small number of sero-negative children who have had heat-treated Factorate are due to be tested for HTLV-III seroconversion during the next week or so.

I promised to return in about 2 months to review the situation.

GRO-C

R. B. CHRISTIE