File Haemophilia Soc

Mr. D. Watters,
The Haemophilia Society,
16 Trinity Street,
London SE1 1DE

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Dear David,

Thank you very much for letting me see Ken Milne's discussion document on factor VIII concentrates. In general I think this is an admirable document although obviously I do have one or two comments. I shall take these one by one :-

1. Para 2 - Although the use of factor VIII concentrates per patient has risen over the years the effect of the AIDS scare in 1983 has yet to be assessed.

2. Para 7 - There are a number of assumptions which are not quite valid in this paragraph :-
   a) I do not understand how the figure 1.75 was calculated.
   b) There is no evidence that 70 patients need factor VIII treatment per million of the population per year. Cutrently the prevalence of treated haemophilia A in the U.K. is about 6 patients per million of the population per year. The prevalence of vWd etc. treated is only about 6 patients per million per year.
   c) The current usage of about 30,000 units per patient per year covers treatment of inhibitors and surgery etc. so I don't see why these are included as an additional therapeutic need.
   d) The requirements given for increased longevity suggests an additional treated haemophiliac per million per year or a rise of 25 patients in the next 25 years. I am not sure that this assumption is correct even allowing for incteased fertility and the figure takes no account of possible eugenics.

   All in all therefore, I would calculate that the assessment based on 50,000 units per patient per year is considerably exagerrated. Although I accept that if side effects had not overtaken us then the use per patient could rise to this figure. Nevertheless over all I still think that the original estimates were realistic and that we shall probably rise to a usage of about 100 million units by the middle of the decade.

3. Para 9 - I agree with the ethical considerations which I think is a good point. I also agree with what Mr. Milne says about the pricing but I think it worth bearing in mind that the BPL (not the BNBTS) has enabled us to compete effectively in the commercial sector resulting in the comparatively low prices paid for commercial concentrates in

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the U.K. With regard to hepatitis I think that Mr. Milne is somewhat complacent. Hepatitis is now the second commonest cause of death in haemophilia after bleeding. Since the ill effects of liver disease may take 20-20 years to manifest themselves we may we well be in for progressive problems from this disease. In this respect by the way, although British material may be no better than imported material I know of not the slightest evidence that it is worse. In this section also reference 11 (to me) is not strictly correct since I am afraid that I 'lifted' this information from Dr. Craske's circular to Haemophilia Centre Directors. He should therefore be given the credit.

4. Para 11 - The BPL is in fact looking into the marginals of convenient presentation etc.

Although I can see a great deal of common sense in Mr. Milne's document, personally I am not quite so complacent about importing American blood products as he and presumably the Subcommittee feel. We must bear in mind that we may not have had the AIDS problem in the U.K. had we been self-sufficient in blood products. At least we certainly wouldn't have this niggling worry about the importation of a hypothetical AIDS virus or other unknown viruses from the New World in the future. Thus, although we must still use imported materials I would not be happy about accepting this situation for ever and I think that it would be nice if the Society could continue to press for an increase in facilities for producing all the necessary factor VIII concentrates within the U.K. It is impossible to look too far into the future and to guess the long-term effects of heated factor VIII concentrates or the future impact of biogenetic material. I hope that these remarks will be of some help to the Subcommittee.

All best wishes,

Yours sincerely,

A.L. Bloom