FACTOR VIII CONCENTRATES & HEPATITIS

(Paper by Dr Peter Jones, Haemophilia Centre, Royal Victoria Infirmary, Newcastle)

Dr Waiter

Thank you for showing me these papers.

Recommendations 1, 2 & 3. I think Dr Modle should be asked to enquire whether these are Dr Jones's interpretation of what was said at the meeting arranged by Travenol and therefore to be regarded as Dr Jones's own recommendations, or whether they are conclusions approved by the meeting.

I think the burden of Dr Biggs' paper, which was accepted by the ad hoc Expert Group in March 1973, was that as concentrate became available it should first be used for severely affected patients and home treatment and eventually less severely and mildly affected patients. It was proposed that the plasma of 400,000 donations (as a minimum) was needed to treat haemophiliacs and that 275,000 of these should be used to prepare concentrate. The Group considered that it might become necessary to discuss with RHAs the problems caused by diminishing the preparation of cryoprecipitate.

Recommendation 1 partly fits this policy. Recommendation 2 does not accord with any of the discussions of the Expert Group or, as far as I can see, with views so far expressed by the majority of the Haemophilia Centre Directors at their annual meetings at Oxford.

It is, therefore, important to discover the origin of these recommendations and also to confirm that there hasn't been a shift of opinion in the country about the role of concentrate vis a vis cryoprecipitate. There is some urgency as the concentrate has now been launched. The ad hoc Expert Group is one body that could be consulted (Dr P Jones became a member at its second meeting in Oct.1974.) The other possibility would be to gauge opinion at the Haemophilia Centre Directors' meeting in Glasgow next September.

Recommendation 3. I'm not quite sure what this means. One could collect plasma containing anti-HB_s and give it prophylactically when patients are given concentrate. Or one could "boost" the anti-HB_s in selected donors by injecting inactivated HB_s Ag. eg. in albumin or PPF, but this would be difficult as these fractions contain very small amounts, if any, of HB_sAg since screening of donors was introduced.

I doubt whether immune plasma would be more convenient than the specific immunoglobulin, in which the antibody content is concentrated 15 to 20 fold compared with that of plasma. I also doubt whether enough immune plasma or specific immunoglobulin could be prepared to protect all the haemophiliacs who will eventually be treated with concentrate.

Dr Jones's conclusion at X is not necessarily true for two reasons: UK plasma is "cleaner" than much plasma used in USA and the fractionation pool size at present proposed here is only 300-400L.

I agree that Y is a generally held view.

GRO-C

16 July 1975