THE ROYAL INFIRMARY OF EDINBURGH

HAEMATOLOGY DEPARTMENT

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Your Ref.:
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16th November, 1984

Dr. I.B. Sutherland,
Community Medicine Specialist,
Royal Infirmary,
Edinburgh.

Dear Dr. Sutherland,

It has recently become apparent to me that some of our patients with haemophilia have antibody to HTLVIII virus. As you will be aware this agent is now thought to be the cause of the Acquired-Immune Deficiency Syndrome.

In consultation with Professor Collee, Dr. Peutherer, and Dr. Edmond, Dr. Parker and I have decided that haemophiliacs who have received concentrates of either factor VIII or IX should be classifed "high infectious risk" patients. The epidemiology of HTLVIII is very similar to hepatitis B and we therefore feel it appropriate that these patients should be managed clinically in the same way as patients who are positive for HBsAg.

We hope that at the clinical end of our service this will not cause too much disruption although it is going to be necessary to offer a reasonable explanation to some of the patients. It does however have major implications for our laboratory. Professor Collee and Dr. Peutherer kindly inspected our laboratory facilities yesterday in the light of the HTLVIII problem and their recommendations will be forthcoming in the near future. Mr. Stephenson represented Mr. Watt at our meeting.

I write to let you know of these recent developments but I do not think any special action is needed by you at present.

Yours sincerely,

C.A.Ludlam
Consultant Haematologist

c.c. Dr. A.C. Parker
Dr. I. Ogilvie
Dr. R.C. Heading
Mr. Purvis

Proposals

The following groups of patients must be treated as High Risk:

(a) Haemophiliac patients who are known to have antibody to HTLV-3 and all other patients who have received Factor VIII or Factor IX concentrates prepared from large numbers of donors.

(b) GUM male homosexual patients with adenopathy and the promiscuous and/or travelled patients.

(c) Clinical Management should follow the hepatitis B protocols circulated by the Hepatitis Advisory Group.

(d) Laboratories must be informed that specimens are from high risk patients and processed according to established High Risk procedures.

Implications

(a) Clinical management: information must be given to surgeons and dentists or any others who may be required to examine and/or investigate the patient in order that High Risk Operative Procedures are applied.

(b) The facilities in Haematology, Clinical Chemistry and STD Diagnostic Lab., will be inadequate to cope with an increased workload of High Risk specimens.

(c) Accidental exposure of staff to blood and secretions of high risk patients. No prophylaxis is available. The incident should be recorded and blood samples collected for full blood and platelet counts, T_h and T_s lymphocyte counts and serum stored at the time and thereafter at 6 month intervals for 2 years.

(d) Diagnostic Service. It is essential that a diagnostic service is introduced as soon as possible, using the facilities available in the University Department of Bacteriololgy. Tests for HTLV-3 antibody and antigen would allow a more accurate assessment of the risk to Health Care Staff, including laboratory workers, and show that the problem was being tackled responsibly.

Dr J.F. Peutherer & Dr E. Edmond,
November 1984.

CONFIDENTIAL

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Summary of meeting held on Wednesday 7 November 1984

Subject: Laboratory and clinical management of patients with evidence of HTLV-3 infection and from groups known to be at risk.

Present: Drs A.C. Parker & C.A. Ludlam, Haematology;
Drs D.H.H. Robertson & A. McMillan, G.U.M;
Dr A. Smith, Clinical Chemistry;
Dr H. Young, STD Diagnostic Lab;
Drs E. Edmond & J.F. Peutherer, Virus Diagnostic and Hepatitis Reference Labs, Bacteriology Department;
Dr F. Bolton, BTS, was unable to attend.

1. Human T-cell leukaemia virus 3 (HTLV-3) and AIDS

This new human retrovirus is now believed to be the aetiological agent of the Acquired Immune Deficiency Syndrome (AIDS). Virus is present in and can be transmitted by close contact with patients' blood, saliva and probably other secretions (similar to hepatitis B). The groups of patients known to be at risk are promiscuous male homosexuals and recipients of blood products, especially Factor VIII concentrates. Antibody to HTLV-3 can be measured and is present in the preclinical stages.

It is important to appreciate that patients with antibody are are infectious and can transmit the virus.

2. General guidelines have been circulated for the management of AIDS patients and their specimens. These patients and specimens should be managed as for patients with hepatitis B.

Local Problems:

(a) It is known from a limited research study that 20 haemophiliac patients have antibody to HTLV-3 and that this infection is associated with the use of a particular batch of Factor VIII concentrate. The patients as yet show no symptomatic evidence of HTLV-3 infection.

(b) It is known, again from a research study, that one homosexual male patient attending GUM clinics has adenopathy and HTLV-3 antibody. Up to 500 male homosexual patients attend clinics each year. Within this group there are, at present, up to 10 who have adenopathy - a feature of the "pre-AIDS" syndrome. There are also as many as 30 patients who must be considered to be seriously at risk because of the very large numbers of their contacts and/or because they have travelled to areas where AIDS is established.