Minutes of the Meeting of Haemophilia Centre Directors
held at the Churchill Hospital, Oxford
on Monday, 5th April, 1971

Present:-

Professor E.K. BLACKBURN, Sheffield Centre. (Chairman)
Dr. R. TURNER, Bradford Centre
Dr. A.A. DAWSON, Aberdeen Centre
Dr. E.E. MAYNE, Belfast Centre
Dr. Jillian MANN, Birmingham Children's Centre
Dr. R.W. WENSLEY, Bristol Centre
Dr. G.P. CLEIN, Cambridge Centre
Dr. A.L. BLOOM, Cardiff Centre
Dr. A. INGLIS, Carlisle Centre
Dr. C.R.R. WYLIE, Derby Centre
Dr. G.R. TUDHOPE, Dundee Centre
Dr. S.H. DAVIES, Edinburgh Centre
Dr. J.O.P. EDGCUMBE, Exeter Centre
Dr. G.P. McNICOL, Glasgow Centre
Dr. J.J. TAYLOR, Hull Centre
Dr. I.A. COOK, Inverness Centre
Dr. L.M. SWINBURNE, Leeds Centre
Dr. T. BLACK, Liverpool Centre
Dr. Helen DODSWORTH, St. Mary's, London
Professor R.M. HARDISTY, Hospital for Sick Children, London
Dr. P. BARKHAN, Guy's Hospital, London
Dr. R. MIBASHAN, Hammersmith Hospital, London
Dr. G.C. JENKINS, The London Hospital
Professor W.M. DAVIDSON, King's College Hospital, London
Dr. C.A. HOLMAN, Lewisham Hospital, London
Professor J.W. STEWART, Middlesex Hospital, London
Dr. K.M. DORMANDY, Royal Free Hospital, London, N.W.3
Dr. E. BENNETT, University College Hospital, London
Dr. G.I.C. INGRAM, St. Thomas's Hospital, London
Professor J.L. STAFFORD, St. George's Hospital, London
Dr. I.W. DELAMORE, Manchester Centre
Dr. H. STERNDALE, Margate Centre
Dr. T.H. BOON, Newcastle Centre
Dr. Rosemary BIGGS, Oxford Centre
Dr. J.R. O'BRIEN, Portsmouth Centre
Dr. D. STERN, Royal Victoria Hospital, Bournemouth
Dr. S.G. RAINSFORD, Lord Mayor Treloar College, Alton
Dr. A. ARONSTAM, Alton General Hospital
Dr. W. D'A. MAYCOCK, The Lister Institute, Elstree
Dr. Jean GRANT, Oxford Regional Blood Transfusion Centre
Dr. Ethel BIDWELL, Plasma Fractionation Laboratory, Oxford
Haemophilia Centre
Dr. W.B. OBANK, Department of Health and Social Security.

Agenda Items 1 and 2:

Dr. Biggs welcomed the Directors and representatives to the second meeting in Oxford. 36 Centres were represented and apologies for absence were received from Dr. M.G. Nelson (represented by Dr. E.E. Mayne), Dr. A.B. Raper (represented by Dr. R.W. Wensley), Dr. J. Stuart (represented by Dr. J. Mann), Professor F.G.J. Hayhoe (represented by Dr. G.P. Clein), Dr. M.C.G. Israels (represented by Dr. I.W. Delamore) and Dr. C.R. Rizza.

Agenda Item 3:

Dr. Biggs gave a short summary of the report on the incidence of jaundice and inhibitors in haemophilic and Christmas disease patients treated during 1969. The full draft report had been precirculated.

ACTION:-

i) Dr. Biggs asked the Directors to send her their detailed comments on the substance and wording of the draft as soon as possible.

ii) She asked any Directors who had figures about Australia antigen and antibody testing to send her these results.

iii) She suggested that the report on the two-year survey of patients treated during 1969 and 1970 be published as from the Haemophilia Centre Directors and from the M.R.C. Cryoprecipitate Working Party. The present two-year detailed survey will terminate on 30.6.71.

About future records that should be kept it was agreed that the following records should be kept:and sent to Oxford at the end of each year:-

a) Detailed record of material given to patients who had inhibitors or who developed jaundice.

b) The full list of names of patients treated (to prevent duplication due to patients attending several Centres).

c) The total amount of material used in a year in terms of the number of donor units.

New forms for this work would be drawn up in Oxford for consideration.

There was discussion about Australia antigen and inhibitors, the substance of which will be presented in items 4 and 5.

Agenda Item 4: Hepatitis and Australia Antigen

The discussion centred on the incidence of Australia antigen (HAA) and antibody in the haemophilic population and the precautions which should be taken to prevent the spread of infection in the wards and among laboratory staff handling blood samples.

Dr. Maycock said that in due course all donor blood would be screened for HAA and that this should reduce the dangers of infection. In the meantime the possibility of infection remained.

About the treatment of patients with HAA positive the main question centred on the precautions which should be taken. Should these patients be treated in the General Wards of hospitals, and if so what precautions should be taken? Dr. Biggs suggested that information about the infectivity of haemophilic patients with HAA positive blood could be obtained by testing the relatives or house contacts of such patients.

ACTION:-

Dr. Ingram agreed to consult with Specialists to see if such a study was feasible. His study should include the possibility of centralised testing for HAA and Dr. Maycock thought that the PHLS might be interested in carrying out the HAA tests.

Dr. Swinburn thought that the haemophilic patients were unlikely to be as infective as the renal patients. He thought that immunosuppressive drugs caused a higher titre of HAA in the renal cases.

It was agreed that reasonable bacteriological precautions should be taken in handling HAA positive material.

ACTION:-

Professor Stafford agreed to collect data from the different Centres about the precautions in use locally and to draw up a general set of proposals

which could be used at all Centres by agreement between the Directors. Local instruction sheets should be sent to Professor J.L. Stafford (Haematology Department, St. George's Hospital, Tooting Grove, London, S.W.17).

The routine testing of staff at Haemophilia Centres was discussed and it was agreed that there were at present objections to such testing. There is no information about the infectivity of people who carry HAA, moreover the carrier state may continue for years and it would be difficult to know how such carriers should be regarded. Depending on the significance of the carrier state, the condition might have to be classed as an Industrial Disease which might raise questions of compensation and difficulties in staff recruitment.

Agenda Item 5: Management of Patients with Inhibitors

There was some discussion about the detection of inhibitors and Dr. Blackburn said that there were three main indications for inhibitor testing:-

a) Resistance to treatment.

b) In all cases for whom surgery was intended (including dental extraction).

c) All new patients.

Dr. Biggs noted that she was still pleased to test samples for inhibitor if this service continued to be useful.

Dr. Davies raised the question of the treatment of patients who developed inhibitor during the post-operative period for major surgery or who had inhibitor and required

major surgery. He recorded that three patients had been treated and all of these were given EACA intravenously in addition to factor VIII. All had survived. Dr. O'Brien also had records of a patient treated with EACA and factor VIII.

Dr. Biggs said that every patient with inhibitor presented an individual problem and that major surgery in these patients was very hazardous and the judgement to decide the best course to take required careful weighing of all the dangers.

Drs. Blackburn and McNicol thought that EACA was contra-indicated in most patients with haematuria.

There was discussion about the possible planning of a trial of EACA in patients with inhibitor requiring surgery. It was felt that such a trial was not feasible or desirable because the cases would be too few and the dangers to these cases were so great that any indication of usefulness (such as the use of intravenous EACA) based on individual case records should be applied in future cases.

ACTION:-

Any case records of patients with inhibitor who had undergone major surgery should be sent to Dr. Biggs for duplication and circulation, and possibly published.

There was discussion on antibody neutralisation by factor VIII. Dr. Bennett described some of her recent experiments which were not yet published.

Agenda Item 6: Factor-IX Concentrates

Dr. Bidwell described the new preparation of factor IX and asked how much would be likely to be needed in England and Wales for the treatment of Christmas disease and other patients. The new preparation could be given by syringe and as at present prepared was low in factor VII.

There was some discussion about the availability of the concentrate and the desirability of using it for patients other than those with Christmas disease. Dr. Bidwell said that at present the material was sent only to Directors of Haemophilia Centres and thus the use of the material for patients other than Christmas disease would depend on the Directors. Dr. Bidwell also stressed the variability of response of patients to the material and the need for control using factor-IX assay. The use of the material in liver disease patients required further study.

Agenda Item 7: Availability of Factor-VIII Concentrates

There was discussion about the presentation of cryo-precipitate as single donor packs. This presentation was not convenient. In general it was felt that some steps ought to be made to provide the cryoprecipitate in a pooled form. It was agreed that although the supply had improved in the last two years, there was still a shortage of material.

ACTION:-

These points should be brought to the attention of the Ministry of Health.

Directors were asked to transmit comments on this subject to Professor E.K. Blackburn so that a letter could be drafted (see also section 8).

Agenda Item 8: Classification, Organisation and Financing of Centres

There was some general discussion about the designation of more and perhaps subsidiary Centres. It was felt that if there were several small Centres in a region there should be free exchange of data about patients between the regional Centres. It was felt that arrangements which prevented long distance travelling by patients should be welcomed, provided that the skill in patient care was maintained. It was felt that the Centres at present listed and designated should be aware of all the patients being treated in their Region.

The present position about the supply of concentrates might cause difficulty if the supply was distributed through many small Centres. It was felt that supplies of cryoprecipitate should be held at the designated Centres and supplied to smaller Centres at the discretion of the designated Centre Director. It was also felt that although treatment for spontaneous bleeding at small Centres might be desirable, the need for factor-VIII assay and experience would require collaboration with a larger Centre for many problems.

The staffing of Haemophilia Centres was discussed. It was clear that the staffing of the Centres did not at present have priority with Regional Boards.

ACTION:-

It was suggested that Directors should send their comments on staffing and designation of Centres to Professor E.K. Blackburn, (The United Sheffield Hospitals, Department of Haematology, The Royal Infirmary, Sheffield, S6 3DA). He would then draft a letter to the Ministry of Health to include also comments on the supply of factor VIII.

Agenda Item 9: Assays of Factor VIII

The NIMR standard for factor VIII had been used at several Centres and doctors had found the ampoules difficult to open and felt that the Hyland standard was better in this respect. Dr. Biggs said that she would transmit this thought to Dr. Bangham (National Institute for Medical Research, London, N.W.7).

It was felt that it would be useful to have samples of known factor-VIII value (e.g. 0.6 and 0.3 u/ml) which could be distributed from time to time on request to serve as quality control of local assays. Dr. Biggs undertook to see if this could be arranged.

Enquiry about the automation of factor-VIII assay and a combined reagent for the assay was answered by Dr. Denson (M.R.C. Laboratory, Oxford Haemophilia Centre) who said that an automated machine made at A.W.R.E. Aldermaston, was under test at Oxford and he hoped that a combined reagent would be available before long. The reagent would be useful also for tests made by hand.

Agenda Item 10: Management of Major Surgery

The subject was raised by Dr. Barkhan and Dr. Biggs replied that the Ministry Circular (HM 68(8)) suggested that where possible major surgery should be done at the designated Major Centres. This was because the experience required for safe major surgery involved many types of hospital staff (surgeons, haematologists, nurses, laboratory staff, physiopherapists, anaesthetists, etc). At the major Centres the control of such patients was now easy and safe and in general managed using human concentrates. It was realised that transfer of sick patients was not always possible and Dr. Boon said that patients might not want to travel long distances from home for surgery and that he now undertook this work. Dr. Biggs said that in fact surgical care probably was done mainly at the designated Major Centres because in 1969 half of the surgical cases were treated in Oxford.

Agenda Item 11: EACA and Dental Extraction

Dr. Walsh gave a short report on the Oxford experience of the use of EACA and factor concentrates in patients having dental extraction. (Full report precirculated).

Dr. Wensley raised the question of treating such patients with EACA alone. Dr. Biggs felt that this should not be done for severely affected patients and Dr. Edgecumbe had tried EACA alone in three fairly severely affected patients and all had bled. The use of acrylic splints was raised and Dr. Walsh said that in Oxford it was felt that these were less useful with better control of haemostasis. The number

of teeth to be removed at one session was raised. Dr. Biggs said that with good haemostasis there should be no limit to the number. Dr. Walsh said that the average in the Oxford trial was 7.5 per session and that several patients had had complete clearance of teeth.

Agenda Item 12: Prophylactic Therapy and Home Treatment

The Directors described their experience in prophylaxis, home treatment and self-administration of factors VIII and IX by patients.

It was generally felt that regular administration of factor IX to severely affected Christmas disease patients was beneficial. Regimes of weekly, fortnightly or even monthly administration had been tried with success. It was felt that such treatment was to be recommended for the very severely affected Christmas disease patient whenever this was possible.

For the classical haemophiliac (factor-VIII deficient patient) such treatment was more difficult. More frequent treatment could be necessary. The supply of material was not adequate. A number of Centres were treating a limited number of patients in this way. It was felt that a controlled trial might be helpful. If agreed, the trial could be of regular weekly treatment for six months and "on demand" treatment for six months.

ACTION:-

Dr. Biggs agreed to test the feasibility of such a trial by drawing up a draft protocol and circulating

this to see how many Directors might be willing and able to co-operate.

Agenda Item 13: Social Educational and Economic Problems

Professor Stewart raised the question of Life Insurance for haemophilic patients and Dr. Ingram said that the Haemophilia Society had studied this problem and Directors should tell patients that they could get advice from the Haemophilia Society.

The treatment of patients on holiday was raised by Dr. Cook. Dr. Blackburn said that the patients should locate the appropriate Centres before going on holiday.

Education was raised by Dr. Bloom and most Directors thought that ordinary schooling was to be preferred for most patients, but that difficulties still existed. There was need for close co-operation between the Head teacher and Haemophilia Centre and some schools still refused to take haemophilic boys.

Dr. Dormandy raised the question of prescription charges but Dr. Obank did not think they could be exempted. He suggested that the patients purchase "season tickets" to cover prescription charges. These cost £3.50 and are valid for 12 months.

Dr. Boon raised the question of employment and said that the Disablement and Resettlement Officers were often helpful.

Agenda Item 14: O.A.B.

Dr. Blackburn asked if the new Haemophilia Cards and Booklet were proving useful. It was suggested that the Canadian booklet was very good and perhaps we should consider making use of its general plan.

Dr. Boon referred to genetic counselling. The general feeling of the meeting was that potential carriers and affected patients should be told exactly the risks involved in passing on the condition so that they could have sound information on which to base decisions.

Dr. Blackburn thanked Dr. Biggs for arranging the meeting and Dr. Grant for the use of the ~~supply~~ room and the catering staff for the lunch.

Meeting broke up at 5.15 p.m.