4498

EXPERT ADVISORY GROUP ON AIDS

MINUTES OF THE SEVENTH MEETING HELD ON 26 NOVEMBER 1985

Present:

Dr E D Acheson - Chairman (morning)
Dr M Abrams - Chairman (afternoon)
Professor M Adler
Professor A L Bloom
Dr J D Cash
Dr M Contreras (morning only)
Dr N S Galbraith
Professor A Geddes
Miss E Jenner
Dr D B L McClelland
Dr P Mortimer
Dr D Pereira-Gray
Dr J W G Smith
Dr R Tedder
Dr R N Thin
Professor R Weiss
Mr R Wells
Professor A J Zuckerman (morning only)

DHSS

Dr A Smithies
Mr C Howard
Dr W Miller
Dr J Modle - item 7 only
Miss B Weller
Dr R Penn
Dr R Raynes
Dr M Sibellas - Medical Secretar
Mr T W S Murray - Secretary
Mrs R C Gorvin
Miss G Woods - Minutes
Dr R G Covell - SHHD
Dr S N Donaldson - DHSS NI
Dr George - WO

Welcome

1. The Chairman welcomed Dr George (WO), who had replaced Dr Ferguson-Lewis and Dr Raynes who had joined the Department's team on AIDS.

Agenda Item 1. Apologies for Absence

2. Apologies had been received from Dr Gunson, Dr Pinching, Dr Ower and Dr Tyrrell.

Chairman's Announcements

3. The Chairman informed members that:

1. the first meeting of the Inter-Departmental Ministerial Group on AIDS would take place on 2 December and would be chaired by Mr Hayhoe;

2. the Department had set up an AIDS Unit with a direct telephone line (Tel No: 01 403 1893).

Agenda item 2. Minutes of the sixth meeting held on 1 October 1985

4. The minutes were agreed subject to the following amendments:

Paragraph 6:1:2

Line 4 to be amended to read:

"..... ascertain the prevalence in homosexual males and in a sample of non-homosexuals."

Paragraph 6:1:5

The figures to be amended as follows:

5	- 13%
5 - 9	- 20%
10 - 19	- 40%

Paragraph 6:1:6

The penultimate sentence to be amended to read:

"..... found one non-haemophiliac patient to be positive out of the 2-300 such patients tested."

Agenda item 3. Matters arising which are not Agenda items
Update on HTLVIII testing - paragraph 7

5. Dr Smithies explained that by 14 October the Regional Transfusion Centres were screening all blood donations. A number of Centres had also been able to test previously donated stocks in hospital blood banks. Centres had been asked to ensure that all hospital blood bank stocks were tested or withdrawn by the end of October. Results were being monitored for the number of positives and by the end of December about ½ million donations would have been assessed.

6. Four Centres were using the Organon kit for testing donations, the remaining 10 Centres were using the Wellcome kit. The performance of the test kits was also being monitored.

Counselling courses - paragraph 10

7. Mr Murray informed members that he and Dr Penn had met Dr Green of St Mary's Hospital to discuss the possibility of increasing the number of training courses and the development of courses to meet the needs of other health professionals. Funding was available for such developments and the Department was now awaiting proposals to be submitted by Dr Green.

8. Financial resources were also available for courses to be mounted in other parts of the country. Approaches had been made to the Regional Medical Officer of the Northern Region and to Professor Geddes (West Midlands RHA). Professor Geddes reported that he was to discuss the matter with the RMO the next day but he was confident that W. Midlands would wish to become involved in developing training facilities.

9. Dr Covell informed members that the St Mary's team had put on a 2 day course in Scotland, which 91 people had attended.

10. In answer to a query by Mr Wells on whether consideration had been given to the use of external counselling agencies, Mr Murray said that the Chairman and he had met representatives of the British Association of Counselling (BAC). BAC ideas on their involvement in AIDS training had not yet been formed up but as a result of the meeting they had been given background material on AIDS to consider. A further meeting would be arranged when BAC had proposals to put forward.

Testing facilities - paragraph 8:3

11. Professor Zuckerman said that he had been asked by his colleagues in Clinical Virology to voice their concern that the PHLS would not be able to cope with increasing demands, especially from Central London and that they, since they were in the front line, must by necessity, carry out tests within their own hospitals. They also wanted to carry out confirmatory tests. Their concern over this had been made public and had been brought to the attention of Members of Parliament.

12. The Chairman replied that the Department had not objected to Departments of Virology carrying out tests. The Department had provided special funds to the PHLS because it was in a unique position to ensure that testing could be introduced effectively on a national basis. Dr Smith said he did not think that testing should be the prerogative only of the PHLS. It was accepted that there would be some circumstances where the PHLS could not meet all needs and that in these situations it was right that clinical virologists should undertake testing on site. However, both Dr Mortimer and Professor Zuckerman agreed that the confirmatory tests should be carried out by PHLS. Dr Thin was of the opinion that if exceptionally there were a major demand on one site, the test and confirmatory test should be done on that site where it was better for patient care.

13. Dr Tedder pointed out that the Thames Regions had been denied money for testing within the specially allocated funding. As a result well-established working relationships between laboratories and hospitals were being eroded since they were having to look elsewhere to get tests done. The Chairman replied that the effectiveness of existing arrangements for testing in the Thames Regions was recognised by the Department. It was hoped that there would be a Ministerial announcement shortly on special AIDS funding for next year.

Agenda item 4. AIDS Surveillance
AIDS Update - CDR: October 1985 - EAGA(7)1

14. Dr Galbraith reported that the November figures were not yet available. The CDSC had used the revised criteria for classifying cases for the first time in the October Report. It was interesting to note that in only 38/224 cases had no additional information been available - this represented 17% whereas when laboratory reporting began the percentage of such cases had been in the region of 50%. About 1,000 reports of male/female HTLVIII sero-positivity had been received so far and of these approximately one-third came within the 'no information' category. Where information was known the spread of the problem broke down as follows: 1/3 homosexual/bisexual; 1/3 haemophiliac; 1/3 others. There were 23 cases of females being infected; of these 10 were known to be heterosexual partners of HTLVIII positive men and 10 were intravenous drug abusers.

Surveillance of cases outside the Defined Risk Groups - EAGA(7)2

15. It was agreed that Dr McEvoy should be invited to speak to her paper at the next meeting.

The Situation in Edinburgh

16. Dr Covell referred to a letter by Dr Peutherer published in the Lancet to the effect that 38% of 106 specimens of serum taken from known intravenous drug abusers in Edinburgh had been found to be HTLVIII positive. Further investigations were being carried out. The Chairman expressed concern about this report since the order of magnitude was greater than that experienced to date. Professor Weiss thought that in view of the high levels of infection in New York the findings were not surprising. However it was not clear if the national prevalence in drug abusers was rising or if there were micropockets, although he would expect the prevalence to rise if needles continued to be shared. Dr Tedder suggested that the drug abusers in London were more street-wise than those in Edinburgh and he therefore expected the prevalence of infection to be lower in London.

17. During the ensuing discussion, the following points were made:

1. in certain parts of the country it was known that discarded needles and waste were being sold for £70 per lot. Advice to Health Authorities about security measures to be taken with regards to the disposal of waste materials needed to be strengthened;

2. a number of young women in Edinburgh who were pregnant or in the post-partum stage were HTLVIII positive; they were contacts of intravenous drug abusers;

3. a study by CDC in the USA had revealed that one of the risk factors of HTLVIII among drug abusers was sharing the same mixing bowls ('works');

4. although the Department had expressed concern about the effects of giving prominence to the possible dangers of HTLVIII Infection in the Drug Abuse Campaign, the time had come for drug abusers and their parents to be warned more forcibly of the dangers;

5. one possible option to control the problem was to supply free needles and syringes. However, whilst the medical profession might see this as a practical infection control measure many would no doubt see such a move as encouraging drug abuse. If such a measure were to be approved, other patients eg, Diabetics would also press for free equipment.

18. In response, the Chairman said that the public education campaign, which was being developed would be targetted at the 'at risk' groups, including drug abusers, as well as the general public. The Agency commissioned to draw up proposals had been in contact with the various organisations concerned with drug abuse. Health education material including posters were already in existence and the Terrence Higgins Trust and SCODA were at present producing a joint leaflet on the subject.

19. With regard to the suggestion that needles and syringes should be provided free of charge he said that this was a matter worthy of further consideration.

Agenda item 5. EAGA Sub Groups
Surgeons, Anaesthetists and Dentists: Draft Guidance - EAGA(7)3

20. The Chairman introduced this item.

21. Mr Wells expressed concern that a number of infection control nurses had designed and were issuing their own 'AIDS hazard' stickers. Because of the threat this posed to confidentiality this could be distressing for patients and it was essential the practice was terminated. The Chairman said there was a duty to inform those who needed to know whether a person was infectious, but unless a person was involved in the treatment of that patient there was no need for that person to know the diagnosis.

22. Dr Smith asked whether surgeons should request tests to be carried out on a routine basis; it was agreed that this should be discussed at a future meeting. The discussion then centred on paragraph 8.2 of the guidance, that is whether a standing agreement was necessary between the clinician ordering the test and the Head of the laboratory and on the type of hazard warning label to be used. On the former, Professor Bloom thought that the arrangements should also cover blood specimens from an HTLVIII positive patient which were sent for testing other than for HTLVIII. Professor Zuckerman thought that should be implicit from the request forms. Professor Geddes described the procedure followed in his hospital. Specimens suspected or known from HTLVIII infected patients were co-ordinated and a biohazard label attached which did not indicate diagnosis. The head of the microbiology laboratory was informed about individual patients and he disseminated the information to those he thought ought to know. It was pointed out that it was not possible to keep information from laboratory staff when only a few patients were involved.

23. The general consensus of the Group was that the guidance should refer to an agreement between the clinician and senior laboratory staff.

24. On the question of hazard warning labels, Professor Zuckerman was of the opinion that they should be ordinary hazard labels which did not give information on the known or suspected illness of the patient. Dr Thin pointed out that if the ACDP revised guidelines recommended different coloured labels for easy identification of different categories of infection, this would be a contravention of the 1974 Venereal Diseases Regulations. Dr Smithies said the ACDP was to consider the question of an overall high risk label at its next meeting on 10 December. It was agreed that the SAD guidelines should be compatible with those being drawn up by the ACDP and the Chairman said that he would ensure a case was put to the ACDP that there should not be special coloured labels.

25. The Chairman said that the comments would be taken into account when the SAD guidelines were revised and if necessary members of the Group [Professor Zuckerman, Miss Jenner and Dr Tedder] would be consulted prior to promulgation of the guidelines.

26. It was agreed that the guidance should be amended as follows:

Section 3 to be amended to read:

> "Although HTLVIII is not as easily transmissible, it would be prudent to take precautions along similar lines to those taken for Hepatitis B."

Section 6 - 3rd line the word "or" to be substituted for "and".

Section 7 - This was considered to be too detailed and the alternative wording:

> "Special care should be taken when dealing with contaminated equipment".

was suggested.

Paragraph 2, line 3 - the word "point" to be inserted after the word "important".

Paragraph 3.2, line 5 - the word "easily" to be inserted after "less".

Paragraph 3.4. This section would have to be updated and the third sentence deleted. Sentence 5 needed to include a reference to the Association of Clinical Microbiologists.

Paragraph 3.5 - this should be followed by paragraph 3.7.

Paragraph 3.6 - the word "substantiated" should be substituted for the word "documented".

Paragraph 4.1. The inclusion at the end of the paragraph of:

> "Where the test is being considered for the purpose of infection control, it will be necessary to obtain the consent of the patient before undertaking it. If a patient refuses in these circumstances to be tested then they should be treated on the assumption that they are positive.

Paragraph 4.2, line 12 the word "normally" to be deleted and the sentence amended to read:

> "It is inappropriate to test a patient for HTLVIII antibodies without their consent except in circumstances where it is an essential part of a series of clinical investigations of signs and symptoms."

Paragraph 4.2, to the end of the section to be renumbered.

New paragraph 4.3 (formerly 4.2). The second sentence to be updated.

The third sentence - delete from "together with" to the end of the sentence and substitute:

> ".... and if there is a risk of splashing, additional protective eyewear."

New paragraph 4.9 (formerly 4.8) to be updated.

Paragraph 5.10 - to include the relevant extract from the Report of the Royal College of Nursing Working Party on AIDS.

Paragraph 8d line one: delete the word "standing".

> line 8 - delete the word "hazard" and substitute "danger of infection specimen."

The paragraph would have to be reviewed in the light of the forthcoming ACDP Guidelines.

Appendix 1.4 - title to be amended to read:

> "National Surveillance of Patients with AIDS."
>
> Line 2 delete the word "register" and substitute "national surveillance".

2.2 The figures seemed high and needed checking; also information was needed on the prevalence outside London together with an indication of how the data was obtained.

27. The point was raised that the guidance needed a reference as to how a patient should dispose of infected dressings when at home. It was agreed that SAD guidelines should contain a reference to the CNO community nursing guidelines.

28. Miss Jenner was concerned that she had written to the Department with a number of suggested amendments which corresponded to those under discussion and which she felt had not been taken into account when the present draft had been drawn up. The Chairman apologised for this and asked the Secretariat to liaise with Miss Jenner.

Employment of Health Care Personnel - EAGA(7)16

29. The Chairman reported that the Sub-Group had held its first meeting on 30 October. A steer was needed from the Expert Advisory Group on the question of restrictions on operative procedures being placed on members of the medical and nursing professions who were HTLVIII positive: no other country had pronounced on this issue. Dr Mortimer drew attention to the MMWR article "Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus type III Lymphadenopathy-Associated Virus in the Workplace" tabled at the meeting. This suggested an announcement on the CDC view would be made shortly. Both he and Professor Zuckerman thought that before any pronouncement was made by the group it should await definite recommendations from America. The Chairman said that enquiries would be made as to when an announcement would be made.

30. With regard to the note of the meeting (EAGA(7)16 also tabled) Professor Zuckerman said that the decision as to whether a person should be considered for a test would be based on clinical judgement - paragraph 3.i. Paragraph 3.ii needed to be clarified: a health care worker in a high risk group ought to consider changing his/her duties within the Health Service; as written the paper suggested that positivity would lead to loss of employment. Dr Tedder's view was that the extrapolation of any action against HTLVIII positive health staff would suggest the screening of all staff. The Chairman stressed that this was not the intention.

31. Professor Zuckerman also reported that the sub-group had not reached a general consensus on whether injections and venepunctures were to be regarded as invasive procedures - for the purpose of the guidelines - he would prefer that the reference were deleted.

AIDS and Renal Units - EAGA(7)4

32. Dr Sibellas reported that the first meeting had taken place on 4 November. Discussion had centred on the screening of patients for HTLVIII antibody and the general consensus was that patients would be likely to give their consent to being tested because they already underwent screening for hepatitis B. The Renal Unit at Newcastle had already carried out patient screening where all patients had been found to be clear. It was not thought that renal unit staff should be tested for HTLVIII antibodies. However, the clinicians on the Group had indicated that if staff were inadventantly found to be positive, they would suggest they were removed to other work within the Health Service.

33. The Group had agreed that each unit should have special provision for treating positive patients. The Group was to initiate a pilot study which involved the screening of all patients and the numbers being reported in confidence to PHLS. A code of practice for the control of HTLVIII infection in dialysis and transplant units was to be developed and referred for EAGA approval.

34. In the ensuing discussion Dr Mortimer suggested that the screening of staff for hepatitis B should be dropped. The Chairman pointed out that one of the problems facing the sub-group was that no guidance had been issued in America. Dr Tedder said the reason for this was the paucity of data on prevalence in organ/semen donors.

Agenda item 6. Health Care Arrangements for Children at School Infected with HTLVIII: Guidance to DES (EAGA(7)5

35. The Chairman welcomed Dr Abrams. He informed members that the Department of Education and Science had formally requested medical advice on the issue; consequently the Department had convened a working group which had drawn up guidance after two meetings. Members of the working group were still commenting on the guidance but these were largely suggestions for the improvement of style rather than content. The final version would however refer to LAV/HTLVIII. He noted that the Department of Education and Science had pointed out that line 5 of paragraph 12 should read ".... infected children should be allowed ..." since legally schools could decide if a child should be excluded for some reason. Dr Cash wondered whether the guidance ought to include a reference to heavily transfused children but the Chairman replied that the guidance had to be general in the sense that it had to cover all HTLVIII positive children. Specific reference was made to haemophiliac children since at present they formed the majority of HTLVIII positive children. The guidance also reflected the necessity to correct the common misconception that haemophiliac children bled externally more than others.

36. The discussion centred around whether gloves ought to be worn by staff when dealing with cuts that were bleeding. It was felt that to wear gloves for accidents in schools involving HTLVIII children would inevitably lead to the identification of the child as being HLTVIII infected - the suggestion was made therefore that gloves should be worn, as a matter of routine when dealing with all accidents involving spillage of blood. Preliminary guidance issued in Scotland about the care of Haemophiliac children had been written on that basis. The Chairman said that the guidance had to meet the specific requirements of DES ie how to deal with HTLVIII infected children. Dr McClelland suggested that in all accidents involving bleeding, protection should be used but that there should be some flexibility built into the arrangements. Members agreed that there should be such a reference to the wearing of gloves wherever possible in paragraph 2 of the Annex. Miss Jenner also pointed out that the paragraph should also include a reference to dilution - if the wound were washed with plenty of water the risk of transmission would be negligible.

37. The discussion then centred on the question who should know if a child was sero-positive. The Chairman said he assumed that in most cases parents would wish to tell the school and that in some circumstances where this did not happen the doctor in charge of the case would inform the doctor responsible for the school. Whilst as few people as possible should know about a child's positivity, he felt that the teacher responsible for the child on a day to day basis ought to know. However, this was a matter which the Inter-Departmental Group would be looking at. Mr Howard pointed out that the School Dental Officer ought to be aware of a child's positivity.

Agenda item 7. The Transmission of HTLVIII by Artificial Insemination by Donor - EAGA(7)6 and EAGA(7)17 tabled)

The part covered does not relate to the matters in question in this action.

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Agenda item 8. Guidance for Opticians/Opthalmologists

42. Dr Sibellas spoke to this item. At the last meeting members had agreed that any advice issued should be based on the recommendations contained in the article "Recommendations for preventing possible transmission of Lymphadenopathy - associated virus/human T-lymphotropic virus type III from tears" published in the Weekly Epidemiological Record, (WER) 20 September 1985. Dr Pincherle had liaised with the Faculty of Ophthalmologists which had subsequently issued the WER advice, which had been published in professional journals, including 'The Optician' . The Faculty had also issued advice to the Association of Contact Lens Manufacturers.

Agenda item 9: National Health Education Campaign

43. Mr Murray informed members that part of the additional monies announced by Mr Hayhoe on 26 September for AIDS was to be devoted to developmental work for a health education campaign. An agency had been retained and had initially concerned itself with market research into the 'at-risk' groups and the general public's knowledge of AIDS and how they responded to existing AIDS literature. The agency was liaising with a number of groups such as the Haemophilia Society, the Terrence Higgins Trust and organisations concerned with drug abuse. A presentation of the Agency's initial findings had been made to Ministers and the Chief Medical Officer. The Departmental Steering Group had now commissioned the agency to develop proposals which might form the basis of a national AIDS information campaign. When these were in a more concrete form, a presentation could be made to the Group. Members welcomed this suggestion.

44. Among other things preliminary research had indicated that some of the language in existing literature was being misconstrued by its target audience. It was therefore essential to ensure that the wording of material could be understood by the various target groups. He felt that it was important to use the expertise of members at this juncture; to identify options for alternative terminology which could be used in campaign material. Mr Wells, Dr Pereira-Grey, Professor Adler and Professor Weiss offered their assistance.

45. With regard to finances, Mr Murray stated that Ministers hoped to make an announcement shortly.

Agenda item 10. International Developments
Legislation and Measures taken to control the spread of the disease

46. Mr Murray reported that in conjunction with the Foreign and Commonwealth Office, the Department had written to over 40 embassies asking for details of

legislation operating or proposed on AIDS and of any other measures which had been taken to contain the spread of the infection. A schedule would be drawn up and circulated to members at the next meeting.

Report of the Brussels Conference on African AIDS (22-23 November '85)

47. Professor Weiss reported that the Conference revealed nothing new scientifically on AIDS. Serological indications were that the infection was becoming widespread in several African counties. Belgian scientists had shown the virus was rapidly spreading in Zaire and Rwanda - many had enteropathic AIDS; fatal in a large number of cases. There was a prevalence of antibodies in one-third of the patients attending genito-urinary medical clinics and general surgical wards. The sex ratio was 1:1. He was himself convinced that since the disease did not affect children, except in some cases congenitally, the main means of transmission was sexual and linked to promiscuity. This was the main message of the Conference. The virus was transmitted from male to female and from female to male. Although he had not seen it expressly stated, the higher the social class of the male, the greater the risk of infection since money determined the number of sexual partners. Prostitutes therefore were at risk. It was clear that some African Governments considered the assumption that the infection originated in Africa to be a great stigma and this had created political difficulties.

48. Mark Essex had presented a paper about the isolation of a virus similar to HTLVIII from the African Green Monkey. It was not clear if the virus were pathogenic in the monkey; the virus could be the progenitor of the AIDS virus and be pathogenic in man. Reference was made to a survey of prostitutes in Senegal, which was outside the AIDS area. A high proportion of the prostitutes had antibodies which cross-reacted with HTLVIII but which reacted more strongly with the monkey virus. Thus, there were a number of sero-positive individuals infected with a virus close to the monkey virus but who were not ill.

49. In the discussion the following points were made:

1. It was not known whether the monkey virus was related to a known genome; it did not correlate in vitro.

2. Although not documented, it had been suggested that people of oriental origin living in gay communities were not contracting AIDS.

3. There could be a connection between promiscuous gay people in the west and promiscuous people in Africa in that the immune systems of promiscuous people were more susceptible to repeated infection.

4. The possible role of insect vectors in the tramission of the infection was not discussed in detail at the meeting.

5. The question of females as passive carriers of the disease had not been discussed at the conference.

Report of the Meeting of Representatives of WHO Collaborating Centres on AIDS on 25/26 September 1985 - EAGA(7)7

Council of Europe: Public Health Committee: Note on AIDS - EAGA(7)8

50. These papers were noted.

Agenda item 11. Risk of Transmission by use of Jet Injectors - EAGA(7)9

51. Mr Murray reported that advice was sought from the Joint Committee on Vaccination and Immunisation about the use of jet injectors and it had recommended that their use should be discouraged generally. Dr Smithies said the decision could have severe resource implications for the Blood Transfusion Service (BTS) since jet injectors were used to introduce the local anaesthetic before blood donations. She requested that the Committee be asked to examine information to be provided by the BTS on the risk, if any, of the transmission, of hepatitis B by jet injector and on the basis of that information to consider allowing the BTS to continue to use jet injectors for local anaesthetic administration. During the discussion the application of the JCVI views to anaesthetics was queried and the Chairman concluded that it would be necessary to:

1. check with the JCVI whether its decision covered vaccinations only;

and 2. request the Regional Transfusion Directors to provide a formal paper on the possible risk of hepatitis B as a result of using jet injectors within the BTS.

Agenda items12 and 13. The safety of the licensed Hepatitis B Vaccine and Immunoglobulin with respect to the transmission of HTLVIII - EAGA(7)10

AIDS and the use of Intramuscular Immunoglobulins - EAGA(7)11

52. Dr Sibellas introduced these items which were taken together.

Hepatitis B Vaccine

53. Members agreed that there was no evidence that HTLVIII infection was transmitted by the hepatitis B vaccine and that it was safe - but this view was based on epidemiological rather than viral grounds.

Human Immunoglobulin

54. Dr Sibellas said that Professor Zuckerman had reported that a WHO Consultative Group which had met in 1983 after considering the data before it had concluded that there was no evidence of risk anticipated to the use of normal or specific immunoglobulin prepared by universally accepted methods. He had requested that the matter be discussed by the Group.

55. Dr Smith said that the safety of intramuscular immunoglobulin had never been questioned: The Committee on the Safety of Medicines (CSM) had formally reviewed them and any questionable preparation was not released. The Committee was to review next month intravenous immunoglobulins which could have transmitted non A/non B Hepatitis. Professor Weiss then referred to an investigation carried out by Dr Webster at Northwick Park, of patients treated with intravenous immunoglobulin. A virus had been isolated from two patients who had received immunoglobulin from two different batches, the source of which was unknown.

Dr Cash informed members that data from America suggested that HTLVIII could pass through cold fractionation II which was the basis of the preparation of intramuscular immunoglobulin.

56. According to Dr Tedder one of the problems with the preparation of immunoglobulin was that there was no mean standard and manufacturers should therefore be asked to make known the procedures used. Dr Smith pointed out that the CSM only considered licensed preparations, immunoglobulins produced by the Blood Products Laboratory, Elstree were not licensed. This was an area which needed to be examined. The Chairman thought that NIBSC should be

asked to consider the problem and to also to liaise with the JCVI. It was agreed that Dr Tedder, Dr Tyrell, and Professor Zuckerman would provide any necessary input from the Group.

Agenda item 14. Consideration of AIDS as a Prescribed Industrial Disease - EAGA (7)15

The part covered does not relate to the matters in question at this action.

Agenda item 15. What is the role of Western Blot as a Test for anti HTLV3/LAV? - EAGA (7)14

58. Dr Mortimer spoke to this paper. He felt that although the test should not be used exclusively, it was one of many to draw on. Members noted the paper.

Agenda item 16. Any Other Business

59. Dr Tedder, on behalf of Dr Contreras asked clinical members whether they would consider asking sero-positive patients as a matter of routine if they had donated blood since 1978 and where blood had been donated, if they would refer their patients to the Regional Transfusion Centre in order that recipients of donations could be followed up. The Chairman noted that this needed to be considered by the full Group at its next meeting.

Agenda item 16. Dates of Next Meetings

60. The following dates were agreed for 1986.

Wednesday 15 January (NB: change)

Tuesday 11 March

Tuesday 20 May

Tuesday 15 July

Tuesday 16 September

Tuesday 18 November