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Your reference

To:
All Members of EAGA

Our reference

Date

10 April 1986

Dear Member — Another

Please find enclosed a copy of the minutes of the meeting held on Tuesday 11 March 1986. The next meeting of the group will be on Tuesday 20 May in Room 64 Hannibal House at 10.30am.

Yours sincerely

GRO-C

MISS G M WOODS
(Secretariat)

ENC:

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IN CONFIDENCE

EXPERT ADVISORY GROUP ON AIDS

MINUTES OF THE NINTH MEETING HELD ON 11 MARCH 1986

Present:

Dr E D Acheson - Chairman
Dr E L Harris
Professor M W Adler
Professor A L Bloom
Dr J D Cash
Dr M Contreras
Dr N S Galbraith
Professor A Geddes
Dr H Gunson
Miss E Jenner
Dr D B L McClelland
Dr P Mortimer
Dr D Pereira-Gray
Dr A J Pinching
Dr J W G Smith
Dr R N Thin
Professor R Weiss
Mr R Wells
Dr J Packer
Dr S Polakoff
Dr G Schild

Dr E Cloake - item 11
Mr C Howard
Dr W Miller
Dr R Moore
Dr D Ower
Dr R Penn
Dr R Raynes
Dr F Rotblat
Dr R Skinner
Miss B Weller

DHSS

Secretariat
Dr M Sibellas - Medical Secretary
Mr T W S Murray - Secretary
Miss G Woods - Minutes
Mr C Burness
Mr W Leason

Dr R G Covell - SHHD
Dr S N Donaldson - DHSS NI
Dr A M George - WO

Agenda item 1: Chairman's Announcements

1. The Chairman welcomed Dr Packer (MOEH, Salford DHA), Dr Polakoff (PHLS), Dr Schild (NIBSC), Dr Rotblat (DHSS Medicines Division) and Dr Skinner (DHSS MEDSEB) who was attending instead of Dr Smithies.

Agenda item 2: Apologies for Absence

2. Apologies had been received from Dr Tedder, Dr Tyrrell and Professor Zuckerman.

Agenda item 3: Minutes of the last meeting held on 15 January 1986

3. These were agreed.

Agenda item 4: Matters Arising

4.1 Artificial Insemination by Donor - EAGA(9)13 - tabled

4. The Chairman explained that he had chaired a meeting in January which had been attended by several members of EAGA and Professor Thompson of the Royal College of Obstetricians and Gynaecologists (RCOG) to consider the RCOG Fertility Sub-Committee's draft guidelines on artificial insemination and AIDS. The aim was to secure a consistent line of advice between EAGA

and the RCOG. As a result the RCOG had revised its guidelines. However he still was concerned that the revision did not deal with the need for counselling before an HTLVIII antibody test was carried out. Dr Penn also pointed out that the suggestion made at the meeting that fresh semen should be tested weekly was considered to be impracticable by the College.

5. The main points of the discussion which followed were:

i. In both the advice to AI Centres and the donors leaflet, Kenya should be included in the list of African countries where AIDs was endemic.

ii. It was felt that the donor leaflet needed to define more closely the terms 'homosexual', 'bisexual' and 'drug abuser' to include those who had at any time indulged in such practices.

iii. Not all AI centres had facilities for freezing semen. Thus a substantial part of the service would cease to function if it were decided that only fresh semen should be used.

iv. Artificial insemination was not a life saving procedure. If fresh semen were to be used the recipients should be given a full explanation supported by a written document so they were aware of possible risks.

6. It was agreed that the Chairman should write to the RCOG with the suggested amendments, stating also that whilst the EAGA would have preferred frozen semen to be used on all occasions, members were aware of the problems this would cause at present but thought that it should be an aim for the future; with these reservations in mind, the EAGA was content with the proposed guidelines.

4.2 Entry Requirement by some countries for HTLVIII antibody tests

7. Mr Murray explained that at the last meeting Dr Cash had asked whether any action could be taken concerning the requirement by Saudia Arabia for inter alia British nationals to undergo an HTLVIII antibody test and have a negative result before being granted a resident's permit. Inquiries made of the British Embassies in Saudia Arabia and the Arab Emirates had revealed that at present the former was the only country which had laid down the requirement. The situation had been brought to the attention of WHO and it was understood that WHO would be making representations to the Saudi Arabian Government.

8. Dr Pinching informed members that at a recent WHO meeting in Kuwait the view was taken that the Saudi Arabian policy was unacceptable on ethical grounds.

9. Mr Murray also reported that Baroness Trumpington had a meeting recently with Sheik Halid Alireza, an eminent Saudi Arabian industrialist, at which the matter was raised. The Department had agreed to provide him with full details so that he could take the matter up with the Saudi Arabian Minister for Health.

Agenda item 5: National Information Campaign

10. The Chairman announced that the campaign would be launched shortly. He hoped to be able to let members know the date and have a copy of the text of the advertisement prior to the actual launch. He noted Dr Pinching's concern over the delay.

Agenda item 9: Safety of Immunoglobulins and Factor VIII and IX - EAGA(9)6 and EAGA (9)7

9.1 Safety of Immunoglobulins - EAGA(9)6

11. Dr Rotblat reported that the minutes of the Biologicals Sub-Committee, appended to her paper, had been endorsed by the Committee on Safety of Medicines (CSM). Consequently she had written to licence holders for immunoglobulins to apply for variations to their product licences to cover the following:

that i. all immunoglobulins preparations should as soon as possible and not later than 1 July 1986 for intravenous and 31 December 1986 for intramuscular be prepared only from donors shown to be HTLVIII antibody negative;

ii. manufacturers should provide evidence of the capacity of their process to inactivate viruses by 1 July 1986 in respect of intravenous, and 31 December 1986 in respect of intramuscular immunoglobulin preparations;

and iii. no material shown to be HTLVIII antibody positive would be released for use.

One response had been received which indicated that (i) was being complied with already. All the companies concerned were carrying out inactivation of virus studies which would be put to the CSM for approval before licence variations were issued. The Blood Products Laboratory (BPL) Elstree was not subject to licensing legislation, however, the Scottish Blood Transfusion Service was carrying out a study on the methods used there. No reports of sero-conversion due to the use of blood products had been received since the last EAGA meeting.

12. Dr Cash wondered whether immunoglobulins made from untested donors should be destroyed by July 1986. Dr Smith said that the withdrawal of outdated material (according to Dr Contreras some hospitals kept immunoglobulins of all kinds for periods up to 5 years) presented no problem; there would be difficulties however, in withdrawing untested material still within its date limit. There was no evidence that intramuscular immunoglobulin was unsafe and withdrawal could be a cause for public alarm. In support of the safety of immunoglobulin, Dr McClelland referred to two studies (1) a fractionation exercise whereby the immunoglobulin was spiked with HTLVIII and the virus was destroyed during the fractionation procedure and (2) a group of 6 children found to have been given intravenous material with high titres of antibodies to HTLVIII had not sero-converted after 6 months. Members were also concerned that if untested immunoglobulins were destroyed, there would be a major shortage. Dr Schild pointed out that special immunoglobulins were difficult to replace and had a long shelf-life. It was agreed that no action should be taken to withdraw immunoglobulins made from untested material.

13. Dr Schild reported that at the NIBSC meeting in February it was suggested that an informal group comprising experts in blood products and AIDs including representatives of the Scottish Fractionation Centre, and BPL Elstree should be established to look at from the point of view of HTLVIII and hepatitis:

i. the technical aspects of production of all blood products

ii. the evaluation of techniques

iii. the surveillance of recipients.

He said that the group could also consider the question of storage of blood products. The group would also carry out a retrospective survey of stored material to check if it contained antibodies.

14. The Chairman welcomed this development but stressed that the Group needed to liaise with the PHLS and also that Dr Tyrrell should be involved in any discussions on research. He asked if the group would first turn its attention to the problem of immunoglobulins. Dr Schild agreed and would report back at the next meeting of EAGA.

9.2 Safety of Factors VIII and IX - EAGA(9)7

15. Dr Rotblat spoke to her paper. She said that Dr Jones had made a statement at the Newcastle Conference in February to the effect heat-treated Factor VIII was not safe with regard to transmission of HTLVIII. In support of this statement he had cited a case in Holland and several in USA. He had subsequently written to the CSM advocating that material manufactured by Armour in particular should be withheld. Dr Rotblat then discussed the cases of sero-conversion after treatment with heat treated Factor VIII:

i. The Dutch patient had sero-converted after 15-16 months after receiving treatment from a batch of Factorate HT. The batch was withdrawn because a donor to the pooled material used in its manufacture had developed AIDS. However, the doctors treating the patient were not convinced that there was no other risk factor involved. The patient was still being treated with Armour material, as were others, none of whom had sero-converted. The Dutch medical profession were concerned at the publicity given to this case.

ii. In England 12 patients had received treatment from a batch of Armour heat treated material which was later withdrawn - the donor referred to in i. above had also contributed to this batch. One patient who had been treated with two bottles from the batch had sero-converted - the result had not been confirmed by Western Blot. The patient was a mild haemophiliac who had received no treatment since 1980. There were no other risk factors involved.

iii. In America, the Bureau of Biologics had confirmed that a patient, a long standing drug abuser, had sero-converted after being treated with Hyland products for injuries sustained in a road traffic accident. He had also received red cell transfusions.

Dr Cash reported that three patients in Scotland had also sero-converted after being given heat treated material.

16. In the dicussion, members were of the opinion that all except one, the mild haemophiliac who had not received treatment since 1980, could be explained by late sero-conversion which was possibly triggered by an accident such as the road accident. Professor Bloom, whilst agreeing that the clinical evidence pointed to the fact that heat-treated Factor VIII was safe, was concerned that Professor Montagnier had reported at a conference at the

College of Pathologists that he had detected reverse transciptase in material heated for 96 hours at 68°C. [Also, the Lancet had reported that the virus was still detectable in spiked material up to 34 hours.]

Dr Smith was of the opinion that the safety margins for Factor VIII which related to the source material and manufacturing processes were adequate. However, Professor Weiss thought it essential that since manufacturing processes varied they needed to be tested empirically and liaison with Dr Schild on this matter would be necessary.

17. The discussion then centred on whether there was a need to issue a statement on the safety of heat-treated Factor VIII to counteract that made by Dr Jones. Although haemophiliacs and their families were reassured about its safety it was recognised that the media were still interested. It was therefore agreed that a statement which included a reference to Factor IX, used in the treatment of Christmas Disease, should be made as follows:

> "The EAGA has carefully considered the safety of currently available Factor VIII and IX concentrates in the light of the most up to date medical information. As a result, the EAGA has concluded that there is no evidence that HTLVIII infection has been transmitted in heat treated Factor VIII and IX concentrates."

The statement would be subject to clearance in the light of discussions by the CSM.

Agenda item 6: AIDS SERVICE PLANNING GUIDELINES - EAGA(9)1

6.1 HTLVIII Infection: District Plans - EAGA(9)(i)

18. Dr Sibellas spoke to her paper. She explained that Health Circular (86)2 issued by the Department on resource assumptions and planning guidelines had asked District Health Authorities to draw up a plan of action with regard to AIDS. This would include special action in respect of high-risk groups and including provision for testing and counselling service and for treating clinical cases of AIDS. These plans were to be submitted to the Department in June. The Group agreed to the suggestion that it would be helpful if the Department was to draw up a checklist to be made available to health authorities of the points which should be incorporated in each District plan. The resulting checklist was designed to meet two principle objectives - the prevention of the spread of HTLVIII and the provision of diagnostic and treatment facilities.

6.2 AIDS SERVICE Planning Guidelines: Comments on the Department's District Outline Plan - EAGA(9)1(ii) - tabled

19. Dr Packer explained that his paper was commenting on an earlier draft of that of the Department. He felt that since service provision varied between health authorities it was right that they should be asked to develop such plans although the question of their implementation was one for the health authorities themselves. He thought it was essential that there was an identified person responsible for taking action and that the District General Manager was probably the best person to undertake this task.

20. The Chairman said it was the Department's view that each District Health Authority had a responsibility to develop on AIDS plan, even if there

were no cases of AIDS within its boundaries at present - such Districts were the very ones which needed to develop a strategy in order to cope with the possible spread of the infection within its area. It was also essential that local developments reflected what was being done nationally.

21. Points emerging from the discussion were:

i. The Department was right to ask all DHAs to prepare plans since there was still a general belief that AIDS was only a problem for London. Without such plans Districts not involved in treating AIDS/HTLVIII cases would be unprepared for future problems.

ii. District plans should pay particular attention to drug addiction and plans needed to identify the high risk groups including drug abusers in each area.

iii. The plans might also indicate those Districts which had "gone over the top" in their policies with regard to AIDS.

iv. The Faculty of Community Medicine was holding a workshop in Sheffield in April at which DMOs would be given assistance in the preparation of plans. The checklist proposed by the Department would be used as a basis for discussion. The Faculty was to produce a training package and it was suggested this should also include model control of infection guidelines.

v. Training.

- In service training should be emphasised since staff in hospitals needed to be prepared for their first AIDS case or scare. Promotional materials, videos and other training aids needed to be developed.

- During training exercises, references should be made to the involvement of General Practitioners in treating AIDS related cases and to the fact that there were standing arrangements for processing blood and specimens which GPs and others needed to be made aware of.

vi. The checklist should contain a glossary of terms as a guide for the District General Manager.

vii. Special Health Authorities needed to be involved in the exercise.

viii. The District Steering Group must include an infection control nurse.

ix. With regard to the Department's paper it was suggested that the reference to the Chief Laboratory Technician should be deleted from the proposed list of members of the Steering Group.

x. Professor Geddes reported that the West Midlands RHA had convened an ad hoc group, which although did not meet often was regularly consulted by the Districts on AIDS problems. Thus, the Region had an oversight of developments and was able to offer advice accordingly.

22. The Chairman said that the checklist would be amended in the light of comments and a revision would be submitted to 2-3 members of EAGA for approval.

Agenda item 7: AIDS Surveillance Update - EAGA(9)2 - tabled

23. Dr Galbraith introduced the paper. He informed members that in 91% of reports of HTLVIII infection received information was being given about categories of cases. He was however concerned that, although there had been an increase in the number of positive HTLVIII antibody tests, there had been a lower than expected increase in AIDS cases and he wondered if reports were being submitted for all cases. Members thought there were several possible reasons:

i. cases were not being reported by the private sector;

ii. reports were being batched together;

iii. as they became more experienced; clinicians were not so enthusiastic about reporting cases;

iv. since the original centres were overloaded, others were being persuaded to accept cases and it could be that these centres were failing to submit reports automatically or even possibly not at all.

24. Dr Pinching was concerned that patient characteristics should be classified in like manner so that true comparisions could be made.

Agenda item 8: Reports of the EAGA Sub-Groups

8.1 Surgeons, Anaesthetists and Dentists

25. Dr Ower reported that the guidance would be issued shortly in the Blue Book series and would be distributed to all doctors. Miss Jenner requested that nurses be included in the distribution. It was agreed that copies should be sent to RNOs and DNOs.

8.2 Employment of HTLVIII Seropositive Health Care Workers

26. Dr Ower reported that the CDC guidelines were still awaited. Mr Wells said the Health Service urgently needed advice on the matter. The RCN had 9 cases pending involving staff who had either been dismissed or suspended by their employing authorities because they were HTLVIII antibody positive. The College was at present considering advising people not to inform their employing authorities of a positive test result. Dr Pinching queried whether there was a need to await CDC's advice before issuing guidance. The Chairman agreed that unless a pronouncement was made shortly, work on issuing the guidance should not be delayed.

8.3 AIDS and Renal Units - EAGA(9)3 and EAGA(9)4

27. Dr Polakoff spoke to her paper. She said that if hepatitis B was used as a model for HTLVIII, then it was a matter of concern for renal units since they were the only places where outbreaks of hepatitis B were likely if preventive measures were not taken. This was due to several factors:

i. the organisation of the unit - large open wards with patients coming in 2-3 times a week for 8-12 hours per session;

ii. patients were heparinised;

iii. renal failure patients already had abnormal immune systems;

iv. patients brought the virus in from outside.

28. Dr Polakoff explained that during the 1960s, there had been a growth in the number of renal units which was followed by reports of outbreaks of hepatitis B. Many had believed that with the development of serological tests and the consequent screening of blood donations, the problem would be overcome. Britain however had taken the view that patients should be screened on a routine basis. Consequently an informal prevention programme had been set up which proved to be successful and by 1973 outbreaks had become controlled.

The problem was whether HTLVIII would act in a similar manner to hepatitis B given that both viruses were transmitted by blood to blood contact. Tests for HTLVIII antibody were sensitive and confirmatory tests were available, however the abnormal immune responses of some patients with chronic renal failure might affect their ability to produce a detectable antibody.

29. It was possible that there were one or two HTLVIII infected patients in renal units at present, although there was no evidence that the virus had spread. Favero maintained that such a situation was unlikely to occur but cited no evidence to support his theory. The sub-group felt that in order to allay any anxieties which might occur, the solution would be to screen patients and maintain surveillance. If patients were found to be HTLVIII antibody positive they should continue to be dialysed in isolation. The sub-group therefore proposed that a screening programme should be instituted and the consultants-in-charge of renal units should be asked to participate.

30. Members accepted the general principle of screening patients and the Chairman pointed out that if a patient refused to be tested, the physician/ surgeon had the discretion to treat the patient as if he were infected. Dr Pinching was concerned that a positive test result should not result in the denial of treatment or refusal of transplantation. The Chairman reassured him that the letter to the consultants which would go from the Department, would include those points and would also stress the need for (a) counselling the patient prior to testing and again if a positive result was obtained and (b) the provision of facilities for treating an infected person in isolation.

8.4 Management of Psychiatric Problems in HTLVIII Positive Patients: Revised Note of Guidance - EAGA(9)5

31. Professor Geddes said that two factors had resulted in the setting up of the group (a) the problems which had arisen when an AIDS patient had to be certified under the Mental Health Act and (b) reports of HTLVIII invading and infecting the brain and giving rise to psychiatric and neurological problems. It was initially believed that AIDS patients with psychiatric problems should be treated in psychiatric hospitals. However, the Group had identified a number of special problems relating to psychiatric hospitals, for example sexual contact between patients was common as were attempts at

suicide, which went against this view. Since the psychiatric implication of AIDS was a new development, little firm guidance could be given at present. However the group had suggested the division of patients into different management categories stressing that the categories were not separate entities but merged with one another.

32. Professor Geddes said the group had drawn up plans for further work and in liaison with the Royal College of Psychiatrists, which was represented on the group, aimed to develop firm proposals.

8.5 Proposed Meeting of Screening Sub-Group to discuss Confirmatory Testing of Blood Donors

33. Dr Skinner reported that a meeting to consider if the accuracy of positive test results confirmed on blood donors were consistent across the country was being arranged for late April.

Agenda item 10: Update on HTLVIII Sero-Testing

34. Dr Gunson reported that up to 31 January 1986 a total of 845,497 donations had been tested, 16 (5 in Scotland, 1 in Northern Ireland and 10 scattered throughout England) of which had been confirmed as being positive. The rate of confirmed positives for the UK was 1 in 52,843. Of the 16, 15 were male and 1 was female. Three of the male donors would not admit to belonging to a high risk group; of the others 1 came from Zambia and the rest were homosexual/bisexual men.

35. The number of repeatable positives using the Wellcome Kit was 63/627,557 and Organon 285/218,940.

36. Dr Gunson also reported that 5,069 donations from the Army Depot at Aldershot had been tested with no positive results and 31,914 from the Republic of Ireland had revealed 2 positive test results.

37. Dr Mortimer pointed out that the incidence of positivity was lower than in America and that the results were to be discussed at a meeting convened by PHLS for 17 March. The Chairman informed members that at a recent meeting of European CMOs, his German counterpart and others believed that in their countries people were donating blood in order to have a test, since charges were levied on tests carried out by the GUM clinics and the costs had to be reclaimed through the social security system. The UK was fortunate in having a system of GUM clinics organised on a national basis where free confidential tests could be carried out.

38. Dr Skinner drew attention to a report (The PHLS and DHSS Evaluation of Commercial Anti-HTLVIII/LAV Assay Kits - 2nd Edition) to be published shortly on the evaluation of screening tests. An earlier report had covered 5 tests, this report would cover 10.

Agenda item 11: HTLVIII Testing for Drug Abusers Attending Abortion Clinics - EAGA(9)8

39. Dr Cloake on introducing her paper said that in the previous few months a small number of drug abusers from abroad were presenting themselves to private nursing homes, mainly in London, for termination of pregnancy. The proprietors were anxious for advice on whether these women should be tested for HTLVIII antibodies before terminations were carried out. The Chairman said that the SAD Guidelines covered the point at issue ie if a

surgeon thought the patient was a drug abuser, he could request the person to have a test as long as the patient was counselled. If the patient declined, the surgeon had discretion to treat her as if she were infected. It was agreed the guidelines should be sent to the nursing homes.

Agenda item 12: AIDS Drug Misusers and Needles

12.1 Report on the First Meeting of the Advisory Committee to Review the extent of HTLVIII infection in Scotland (Scottish Committee on HTLVIII Infection and Intravenous Drug Misuse) - EAGA(9)9 - tabled

12.2 Situation in Amsterdam - EAGA(9)10 - tabled

40. Dr McClelland, the chairman of the Scottish Committee, said that since intravenous drug abusers were heterosexually active, they could be responsible for a spread of HTLVIII outside the high risk groups. The evidence from Africa about heterosexual spread had been noted by the Committee and it was thought possible the same situation could arise. Of the 494 positive reports from Scotland, 330 were intravenous drug abusers, most of whom came from Edinburgh or Dundee; a notable contrast to Glasgow where 6/900 drug abusers were HTLVIII antibody positive and to the situation in England where there was a low prevalence among this group. However, many cities in Italy and France were experiencing a similar situation to that in Edinburgh. The Committee therefore felt its immediate task was to examine steps to reduce the transmission of the infection. It had discussed the value of issuing free needles but were more attracted to the idea that practitioners who thought it necessary to issue needles/syringes to their patients should be encouraged to do so and that it should be done on a 1-1 exchange basis for a used needle/syringe. A similar scheme was being operated in Amsterdam.

41. The Committee also thought that if health authorities could maintain regular contact with drug abusers, they could be kept under surveillance and to a certain extent monitored. Lines of communication would thus be established which would facilitate the implementation of new policies. This was in line with the approach adopted by the City of Amsterdam with regard to treating heroin addicts with methadone.

42. Dr Pinching was in favour of measures being introduced to prevent the spread of HTLVIII infection among drug abusers but felt there was a conceptual block regarding infection control in this area. Failure to do anything would result in a high prevalence of HTLVIII and he suggested that needles and syringes should be available through multiple outlets. Dr Covell said that the Committee felt strongly that the issue of equipment should be controlled by the medical profession and was worried that if outlets were increased, the issue of equipment on an exchange basis could not be controlled. Dr Ower however reported that the Pharmaceutical Society had recently relaxed its rules on the issue of needles and had advised pharmacists that they could sell needles to drug abusers as long as counselling was given. EAGA members were agreed that the disposal of used equipment needed to be tightly controlled to prevent further abuse.

43. The Chairman noted the comments. He said he would discuss the matter further with Dr MacDonald. It was agreed that a member of EAGA should attend the next meeting of the Scottish Committee.

Agenda item 13: Counselling Training Courses - Oral Report

44. Mr Murray reported that proposals for courses for 1986/87 had been submitted by St Mary's, Paddington; Birmingham and Manchester, and that he expected a decision on funding to be finalised shortly. The increased capacity, an extra 1,500 places, would mean that demands for courses would be satisfied. The courses would not be just for GUM staff. Wider groups of health professionals and local authority staff working with people with AIDS or who were HTLVIII infected would also be able to attend some of the courses. Courses at St Mary's would be multi-disciplinary whilst those at Birmingham and Manchester would probably be uni-disciplinary. The commencement date of courses at the latter two centres would be dependent on the appointment of the necessary training personnel.

Agenda item 14: Any Other Business

14.1 SCODA

45. Dr Pinching was concerned that SCODA was no longer receiving any funding for the health worker who had been seconded to work on the health education project and asked if the Departmen could assist. Mr Murray advised that the situation had resulted from a rejected grant application to a charitable trust. The Department was now considering a grant application to fund the post.

14.3 Rare Cell Frozen Blood Banks - EAGA(9)12

46. Dr Sibellas told members that Professor Zuckerman had submitted a query on behalf of Dr Knowles, Consultant Haemotologist at NE Thames Regional Transfusion Centre. She was concerned whether in an emergency transfusion support for a patient with rare genotypes should be withheld because the supply of red cells came from untested stock.

47. Dr Gunson thought this was a matter for the Regional Transfusion Directors to consider and said he would raise it at their next meeting.

14.3 Adoption

48. Dr Pinching said he was often asked by adoption agencies for advice on whether children waiting to be adopted should be tested for HTLVIII antibodies. It was agreed that a sub-group should be set up to look at this matter.

Agenda item 15: Date of Next Meeting

49. The next meeting will be held on Tuesday, 20 May 1986 in Room 64 Hannibal House at 10.30 am.