

18th July, 1972

Dear Mr. Trillwood,

During the past twelve months we have been experiencing increasing difficulties in meeting the needs for AHG for our haemophilic patients. At present we rely entirely upon human cryoprecipitate supplied by Dr. Grant of the Regional Blood Transfusion Centre and freeze-dried human AHG concentrate supplied by Dr. Bidwell of the Plasma Fractionation Laboratory, supplemented by a small amount of human AHG from the Lister Institute of Preventive Medicine, Elstree. During 1971 we received and used concentrates of human blood clotting factors derived from more than 20,000 blood donors. This material was mainly from donors in the Oxford Region and we are deeply indebted to the Regional Blood Transfusion Service for the co-operation over the years which has made it possible for them to channel plasma from nearly a quarter of the total donations of the Region into the fractionation process.

Despite this seemingly excellent supply, we are chronically short of material to treat the ever increasing number of patients that come to Oxford. This shortage is not new and we have always had to give priority for treatment to emergency cases and to the treatment of children to prevent crippling deformity. This restriction has meant that the surgical waiting list for patients requiring non-urgent operations has grown and at present 25 patients are on the list. About half of the patients treated in Oxford during 1971 were from the Oxford Region and half were from other parts of the United Kingdom.

Until recently this shortage of therapeutic material was unavoidable since no suitable commercial material derived from human blood was available. There are now two sources of supply, one is from the Hyland Laboratories and the other is from Immuno A.G. of Vienna. Both are expensive and it would require material to the value of £2,000 to treat one operation case. Both of these preparations are clinically effective and have been used extensively in other countries. The Immuno concentrate has the advantage of being derived from blood which has been tested and found to be free of Hepatitis Associated Antigen, thus diminishing the risk of hepatitis.

At present we are often forced to balance the needs of one patient against those of another in allocating treatment. This potentially dangerous practice was reasonable when there was no alternative supply of therapeutic material. We feel now that good material is available commercially our supply should be supplemented by the use of this commercially available concentrate. It seems to us quite unethical to continue to withhold treatment from patients when material exists to supply their needs.

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(41)

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We therefore ask that the Immuno AG factor VIII (AHG) concentrate be bought at an estimated cost of about £15,000 per annum for use at the Oxford Haemophilia Centre. About half of the patients for whom this material would be used would come from other regions and most of the material would go to cover patients requiring major surgery. This additional supply would much increase the safety margin for the treatment of urgent cases and would permit us over the years to lessen the waiting list for non-urgent operations.

Yours sincerely,

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Consultant Physician

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c.c.: Dr. Biggs  
Dr. Bidwell  
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