Witness Name: Alice Mackie

Statement No.: WITN2189005

Exhibits: WITN2189006 – WITN2189065

Dated: 30th April 2021

INFECTED BLOOD INQUIRY

EXHIBIT WITN2189028

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

Note of a meeting convened by Welsh Office, Medical Services Health Professional Group 4 May 1983

In attendance:-

Dr G Crompton Dr W C D Lovett Dr A M George Dr D Ferguson Lewis	)	Welsh Office
Dr M McEvoy	-	Communicable Disease Surveillance Centre (CDSC)
Dr J F Skone	-	Chief Administrative Medical Officer South Glamorgan Health Authority
Dr A Napier	-	Welsh region Director of National Blood Transfusion Service (NBTS)
Professor A Bloom	-	Professor Department of Haematology, Welsh National School of Medicine, Director Cardiff Haemophilia Centre

The meeting was arranged to discuss the background circumstances of, and implications arising from, a publicly reported case of AIDS treated at the University Hospital of Wales.

Background History

A young man, domiciled in GRO-A, of some 20 years of age and a severe haemophiliac has had throughout his life treatment with factor 8 concentrates of various sources. In the period 1979-81 he was at GRO-A and details of treatment while there are being sought. Since then (that is, 1981, 1982, 1983) he has had only British factor 8 concentrate - prior to 1981 he did have Austrian made factor 8 but it is not known from which sources of blood supply this was manufactured and he certainly had a considerable amount of factor 8 before 1979.

Just before the Christmas of 1982 he developed oral thrush which progressed despite treatment initiated by the general practitioner with mystatin. He eventually presented with a total leukopenia, a severe lymphopenia, a deficiency of T lymphoeytes, a deficiency of T helper cells, a reduced helper:supressor T cell ratio, and a history of a recent weight loss of one stone which was thought mainly due to the difficulty in eating and swallowing occasioned by thrush, later treated with a satisfactory response using ketoconazole.

Somewhat distrubingly 10 days ago the patient presented again with epididymal orchitis, the aetiology is unknown but he may have had a bleed into the right testes. The patient improved on injections of intravenous Gentamicin.

There is a protracted history of repeated attacks of tonsillitis. The known social history does not place the young man in the general at risk category as a consequence of community associations.

Medical Assessment

It is clear that this young man presents a clinical picture which fits within the case definition as set by the CDSC at Colindale.

Public Statements

On 23 April, Professor Bloom addressed a meeting of a patients haemophilia society in London. He spoke from a typed manuscript in which reference was made to the fact that there was no definite case of AIDS amongst haemophiliacs in this country.

However in a discussion which followed he admitted that a case had been treated in Cardiff which showed some of the features of a mild possible AIDS.

On Thursday 28 April, Susan Douglas, medical correspondent of 'The Mail' made contact stating that she knew that Professor Bloom was treating a patient with AIDS saying she had been so informed from a number of undisclosed sources. Professor Bloom neither confirmed nor denied the statement.

Yesterday, Tuesday 3 May, 'The South Wales Argus', rang Professor Bloom to ask whether the patient reported in the press was a Gwent patient. There being so few haemophiliacs in any given location it was important not to give any information and Professor Bloom would not comment.

Professor Bloom has provided all relevant information as a precautionary measure to the Medical Protection Society. Only one patient has telephoned in seeking information and advice.

'Guardian Reports' of the 4 May 1983 - The Andrew Vatch column attempts to place matters in perspective. However the Richard Boston feature aided by Reg Bird of the ASTMS implies that with foresight and the expenditure of an unspecified sum we could have avoided the present consequences of reliance upon imported blood products is based on a false premis. That argument was initially advanced with the intention of avoiding Hepatitis B, from that point of view European or British blood is not any safer than that collected in the USA. It also has to be remembered that at the time of planning the condition known as AIDS had not been identified.

It is believed that the Haemophiliac Society's London Liaison office is to take up with the Press Council the matter of enquiry through misrepresentation as a result of approaches they have received from the press.

Communicable Disease Surveillance Centre, Colindale

Colindale had received notification of the Cardiff case but has no information in respect of the second alleged case referred to in The Mail article of Sunday 1 May 1983. The Cardiff case fits the CDSC case definition with its depressed cellular activity and immuno-suppresion deficiency. Haemophilia directors and public health laboratory services have been circulated with a description of AIDS and a statistical office has been established in Oxford. Some 14 cases or so have been reported none of whom were haemophiliacs all of greater severity than the Cardiff case. The CDSC has been similarly bombarded with telephone enquiries from the press.

System of Reporting AIDS to CDSC

Three mechanisms exist:-

a. OPCS - death registrations (from 1 January 1982) provided to CDSC

b. Laboratory Reports to CDSC by microbiologists

c. Clinical Reports - from venereology and dermatology consultants

It is believed that CDSC data under-estimates the problem because patients may present to doctors in other specialties. Letters have been published in the Journals inviting wider reporting (BMJ 23 April 1983).

Impact of Publicity on NBTS in Wales

It was important to keep the problem in perspective. There was complete awareness of the evolution of the problem which in America has seemingly developed as a result of two coincidental factors, an increased use of blood and its products within an increasingly permissive society where homosexuality is tolerated and drug abuse common. Donor screening and donor selection produces problems - it would, for example, be possible to ask more searching questions regarding weight loss, night sweats etc but a clinical examination of donors has manpower implications of a scale not hitherto imagined and even if this was to be conducted by trained nursing staff would not be easily performed in the circumstances within which blood collection is made in this country. It would be practicable for the smaller donor population of regular commitment to plasmaphoresis. Firm guidance in a descreet fashion and reassurance would be welcome with emphasis placed upon the donor population that is risky. Given that the reported incidence of AIDS in the UK is very low we might be confident that we are not collecting potentially contaminated blood.

American Experience of Blood Transfusion/Bld Products Association with AIDS

Two cases have been reported in patients receiving whole blood one of which concerned a child. One dozen cases have been reported amongst haemophiliacs in receipt of Factor 8 as compared overall to some 1500 cases known in USA with reports to Atlanta at a rate of 100/wk. Public Health measures in the USA includes the avoidance of preparation of cryoprecipitate from blood collected amongst high risk groups and perhaps more importantly the non targetting of the high risk groups viz homosexuals, Haitians and intravenous drug abusers for blood collection purposes.

Extent of Reliance upon USA Component?

We are still reliant to a very large extent upon the USA - some 50% of factor 8 is still obtained from that source.

What would be the effect of a ban of American Factor 8?

The effects would be far reaching. Instead of the ready access to 60 million units of factor 8 now available only 30 million units would be accessible exactly half current requirements. Blood product laboratories in the UK are presently working to capacity. If we were in Wales to attempt locally to make good our own deficit it would require a great deal of extra facility within the NBTS at Rhydlafar. It follows that a ban on imported factor 8 would necessitate:-

a. a reduction in patients treated;

b. the modification of the home treatment facility (with the associated consequences of lost jobs with implications for social services as well as for the health service).

What is the size of the haemophilia population?

In the United Kingdom as a whole there are about 2,200 patients with haemophilia of whom there are 100 resident in Wales catered for by South Wales based services principally the Cardiff Haemophilia Centre. Patients who are haemophiliacs and resident in North Wales are looked after by Liverpool.

Can we go on using factor 8?

The asserted greater risk arising from the use of purchased blood as opposed to voluntary donated blood in less than hitherto with the greater awareness of the AIDS problem. People like haemophiliacs who are otherwise healthy who receive solely blood from voluntary donors exhibit a lower prevalence of abnormal immuno-suppression than those treated with commercial concentrates. Strictly this is not comparing like with like but the evidence from the United States is supported by other evidence from the Continent.

There is no justification on the basis of facts so far established to ban the importation of factor 8 though it was thought preferable in the case of children to restrict treatment to the BPL concentrate produced in Britain.

Nursing and Laboratory Precautions in Handling Patients

The Atlanta recommendations do not call for isolation of patients but pathology material is handled along the guidelines as for Hepatitis B.

Suggested Further Action

i. A letter in confidence from CMO to Chief Administrative Medical Officers and all consultant clinicians (since the widely differing presentation of the disease extends beyond the boundaries of venereology and dermatology).

ii. Agenda item for next CAMOs meeting.

GRO-C

5 May 1983

D FERGUSON LEWIS
Senior Medical Officer