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LEADING ARTICLES

CLINICAL RESEARCH • PAPERS AND SHORT REPORTS • PRACTICE OBSERVED

MEDICAL PRACTICE

NEWS AND NOTES

SUPPLEMENT

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CORRESPONDENCE

Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.

Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.

HTLV-III, haemophilia, and blood transfusion

SIR,—We are writing on behalf of the directors of the UK haemophilia reference centres to express our concern about the safety of blood and unheated blood products.

The acquired immune deficiency syndrome (AIDS) is now the most important complication of treatment for haemophilia. By the end of April 1985 over 60 American and 20 European haemophiliacs with this disorder had been reported and about half of these had died. In haemophiliacs the prevalence of antibody to the causative agent HTLV-III in the UK has been rising since 1980,[1] mainly due to the use of unheated concentrate of factor VIII imported from America. However, seroconversion is also appearing in patients with haemophilia A treated only with factor VIII concentrates derived from UK plasma (Ludlum CA, Tucker J, Steel CM, *et al*, personal communication) and also in patients with haemophilia B treated only with locally produced factor IX concentrate.[1] Suggestions have already been made for using heat treated dried factor VIII concentrates since HTLV-III is known to be heat sensitive.[2,3] A similar case could also be made for using heat treated factor IX concentrate. However, in some categories of patients cryoprecipitate was considered to be the most appropriate treatment.[3]

To assess the impact of these recommendations on treatment for haemophilia in the UK the directors of the 109 haemophilia centres were circulated in May 1985 with a short questionnaire; 83 replies were received (table). Many centres were using cryoprecipitate and a substantial number were still using unheated UK factor VIII concentrate, but this may have represented clearing of existing stock. Only a few centres were using heat treated factor IX concentrate, presumably because this must be purchased from commercial sources whereas the unheated material is supplied "free" from the UK manufacturers. Heat treated UK factor IX is not yet available.

The figures have some disturbing implications. Without doubt the prevalence of HTLV-III infection in the homosexual population and other potential blood donors is increasing.[4] The safety of cryoprecipitate and unheated UK blood products with regard to HTLV-III infection can therefore no longer be assumed, especially as these materials may need to be administered in repeated doses. Although there may be regional variations in donor positivity for HTLV-III antibody, we no longer consider that the use of cryoprecipitate or other non-heat treated concentrates is justified. Nor is this problem confined to patients with haemophilia. Although the risk from ordinary blood transfusion is still very small, it is undoubtedly increasing from the previous estimate of one in 100 000.[2] Certain patients, such as those undergoing open heart surgery or those with acute leukaemias or other haematological disorders, may easily receive whole blood, platelet transfusions, cryoprecipitate, or other blood derivatives from 50 or more donors in a short space of time. The risk of HTLV-III infection in such patients could now be as high as one in 20 in certain areas of Britain.

All these considerations underline the need rapidly to introduce screening for HTLV-III antibody for all blood donations. Three commercial test kits have now been approved by the American Food and Drug Administration and, although there may be a small number of false positives, it is unreasonable to delay testing until this possibility is eliminated. Donations which are found to be positive for HTLV-III antibodies should be discarded. The logistics of retesting, confirmatory testing, and donor counselling can then be dealt with as separate important issues, as discussed in detail in the excellent review of Osterholm *et al*.[5] We believe that donors would readily accept this interim measure because, after all, they are themselves potential recipients. Although such testing will be expensive, we think that it should be implemented as soon as possible to protect recipients and to preserve public confidence in our blood transfusion services. When testing is fully implemented the role of single donor cryoprecipitate in the management of haemophilia can then be reassessed.

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Factor VIII and IX concentrate use in UK

Concentrate type	Concentrate used: Yes	Concentrate used: No	Comment
Unheated commercial VIII	1	82	
Children unheated commercial VIII	0	83	
Unheated domestic VIII	33*	48	
Children unheated domestic VIII	15*		
Cryoprecipitate	73	10	
Heated commercial VIII	66	17†	
Heated domestic VIII	46	36	Not yet freely available
Unheated domestic IX	55	12	
Heated commercial IX	14	50	Two centres use both heated and unheated
Neither IX	14		Presumed too few cases of haemophilia B

* Includes three centres using it only for patients with HTLV-III antibodies.
† Includes five Scottish centres using heated domestic VIII. Others include small centres using unheated domestic VIII or cryoprecipitate.