IRISH HAEMOPHILIA SOCIETY

TRIBUNAL NEWSLETTER

ISSUE 40

CONTENTS:

25th February 2002

TRIBUNAL OF INQUIRY

(Into the Infection with HIV and Hepatitis C of Persons with Haemophilia and Related Matters)

PROCEEDINGS: Monday 17th September 2001 - Day 168

Today, Dr. Paul Giangrande gave evidence. He is a Consultant Haematologist at the Oxford Radcliffe Infirmary. He is also the Director of the Haemophilia Centre in Churchill Hospital in Oxford.

Dr. Giangrande gave evidence that a study carried out in the UK showed that patients treated with super-heat-treated factor VIII product did not become infected with Hepatitis C. By 1993, 80 per cent of people with haemophilia who attended the Oxford Centre, had been informed of their HCV status. By the end of 1993, 95 per cent had been tested. Once patients had been tested for Hepatitis C, if the result was positive they were asked if they wanted to be referred to see a liver specialist.

Dr. Giangrande was examined by Mr. Martin Hayden, Senior Counsel for the Irish Haemophilia Society. He emphasised that in Oxford, medical practitioners were very aware of the need to sensitively inform people of their Hepatitis C status. In Oxford they had established a database which contained information on exactly what treatment each patient had received. This database made it very easy to identify patients who may have been infected with either HIV or Hepatitis C, and also facilitated in the operation of a look-back programme.

With regard to the increasing risk of liver disease arising from Hepatitis C, Dr. Giangrande said that studies showed that the risk appeared to be increasing and that there was no evidence of a plateau in the figures. On the other hand, Dr. Giangrande said that the treatment in the form of a combination of drugs had had a good effect on the life expectancy of those people infected with HIV.

With regard to treatment available for Hepatitis C, Dr. Giangrande said that in order to prevent serious or fatal damage to the liver, or cirrhosis, it was important that patients be treated early. Those patients who had not been treated in time could suffer serious scarring of the liver.

Dr. Giangrande described how there were six nurses in the Oxford Centre, two Junior Doctors, two Senior House Officers, all of whom were responsible for the care of people with haemophilia who had contacted Hepatitis C. Dr. Giangrande said that there were procedures in place for dealing with informing patients of their Hepatitis C status. It was the policy of the Centre in Oxford to ensure that patients were both informed of their Hepatitis C status and treated as quickly as possible.

Following the introduction of super-heat-treated factor VIII and factor IX concentrates in the UK in 1985, there is no evidence that any person with haemophilia treated with those products became infected with Hepatitis C.

PROCEEDINGS: Thursday 20th September 2001 - Day 169

Dr. Bernard Horowitz gave evidence to the Tribunal. Dr. Horowitz spent much of his career at the New York Blood Center. He was one of the pioneers of the solvent/detergent viral inactivation system that was developed by the New York Blood Center. Dr. Horowitz was with the New York Blood Centre from 1974 until 1994. During that time, the Center was responsible for blood collection and distribution in the New York Metropolitan area, serving 18-20 million people. The Center had a substantial research enterprise - the Lesley Kimball Research Institute. It owned and operated a fractionation facility and in 1985 was processing upwards of 350,000 litres of plasma.

Dr. Horowitz described the development of various viral inactivation techniques undertaken by the New York Blood Center. Dr. Horowitz said that prior to the advent of the HIV threat, the primary aim of viral inactivation was the prevention of Hepatitis. Dr. Horowitz described the development of various inactivation techniques and the introduction of heat treatment. He said that heat treatment in itself was not a guarantee of viral inactivation. Dr. Horowitz said it was generally known, by the end of 1985, that viral inactivation by heat treatment to temperatures of up to 68 degrees was ineffective for Non-A, Non-B Hepatitis. In 1985 and going into 1986 and 1987, there was a general move away from heat treatment as a method of viral inactivation. Significantly, for products produced by the BTSB, heat treatment continued to be used as the method of viral inactivation throughout 1987, 1988 and 1989.

With regard to the joint manufacture of factor IX, as happened between the BTSB and Armour, Dr. Horowitz said there was no problem with such joint manufacturing per se. However, one would have to have confidence in the viral inactivation step in that it should be well executed and validation studies should take place.

Dr. Horowitz commented on the development of the solvent/detergent viral inactivation techniques by the New York Blood Center. The first information concerning this type of viral inactivation was published in 1985 with the FDA awarding a licence in May 1985. Studies had taken place on solvent/detergent as a method of viral inactivation between 1983 and 1985.

Dr. Horowitz pointed out that the New York Blood Center was a not for profit organisation. It distributed its knowledge and technology on a broad basis. However, he said that the New York Blood Center was a fractionation facility and was not a blood bank. As far as he was aware, the New York Blood Center had no contact with the BTSB. Solvent/detergent factor VIII and factor IX were available from the New York Blood Center from 1985 until 1988. However, Dr. Horowitz said solvent/detergent viral inactivation was not a blood bank procedure; it was a fractionation procedure. He said it was simple but it must be validated.

Dr. Horowitz was questioned by Mr. Michael McGrath S.C. for the BTSB.

Dr. Horowitz was cross examined by Mr. Raymond Bradley for the Irish Haemophilia Society. He agreed that initial studies concerning viral inactivation at the New York Blood Center were motivated by the elimination of Hepatitis B and Non-A, Non-B Hepatitis. Dr. Horowitz said that in his experience, blood banks in the U.S. do not participate in contract fractionation, but tend to concentrate on the business of blood banking. He also noted that a customer with 18,000 – 30,000 litres of plasma for fractionation would have a broad range of fractionators to choose from.

The virtues of solvent/detergent viral inactivation techniques were that yield ranged from 90-100%. There was a decrease in inhibitors and a decrease in any risk of thrombogenicity. There was a high virus kill, and studies with chimpanzees indicated clear evidence of Non-A, Non-B safety. On the other hand,

the treatment at 60 degrees failed to protect recipients from Non-A, Non-B Hepatitis. All this information was available in 1985.

PROCEEDINGS: Friday 21st September 2001 - Day 170

Today, Ms. Jo Campion, Psychologist, gave evidence. Since 1996, Ms. Campion has been appointed by a number of health boards to provide a counselling service to people who had been diagnosed with Hepatitis C. She said that her initial involvement with people with Hepatitis C came through the ladies who were infected by the Anti-D product. She subsequently became involved with renal patients who had been diagnosed with Hepatitis C, and later with people with haemophilia.

She said that it was now universally accepted that shock is a primary reaction of people who are diagnosed with life-threatening illnesses. Shock is usually replaced by denial. Many people, according to Ms. Campion, become increasingly anxious and vulnerable, and often consider that there is no point in going on. There are also feelings of isolation and loneliness.

Counselling is an important part of being able to effectively deal with the shock and trauma of being diagnosed with a life threatening disease, according to Ms. Campion. She said that it is not only the people themselves, but their family also requires counselling.

Ms. Campion said many people go into denial as a means of coping with the crisis. Because they cannot cope with the difficulties that they are faced with, they try to block them out. She said it was very common to see people abusing alcohol or other drugs in order to cope with the burden of their diagnosis. If the person doesn't pass on to the denial stage, they can become clinically depressed. Ms. Campion said that many of the people she counselled who had been diagnosed with HIV had contemplated suicide.

She said it was also noticeable that some people had adopted self-harm practices. Many people with haemophilia could seriously damage themselves if they didn't treat themselves for a bleed, and Ms. Campion described this behaviour as passive harm. She said that a significant number of people diagnosed with HIV had abused alcohol as a means of coping. Ms. Campion did say, however, that the number of people who had adopted practices of self-harm was a small harm.

Ms. Campion said that early intervention with counselling could often prevent people falling into serious depression. She went on to say that she had observed in people with haemophilia who were not infected with HIV a tremendous feeling of guilt. She said that the haemophilia community was a very close knit one, and that those who were not infected often suffered from what is described as survivor's guilt. She said other kinds of guilt caused problems: she reported a number of incidents where people who had been diagnosed with HIV were married and their wives were pregnant at the times of the diagnosis. Many people who were diagnosed with HIV while their wives were pregnant felt a greater anger and bitterness because they were prevented from enjoying the natural pleasures of parenthood. Ms. Campion went on to say that the effects of diagnosis with HIV had other psychological and social effects. For example, if a father was diagnosed with HIV, it was common to see a role change within the family where the father became dependent and reliant rather than, as previously, acting as a provider.

Ms. Campion described her experience participating in a team of medical professionals in hospital. She said that the team would often be made up of a doctor, occupational therapist, physiotherapist and clinical psychologist. She said, in her experience, early intervention by a clinical psychologist was part of one of these teams had a very positive effect on people who had been diagnosed with life threatening diseases.

Ms. Campion, examined by Mr. Bradley on behalf of the Irish Haemophilia Society, stressed the importance of early intervention of a psychologist following the diagnosis of a life-threatening disease.

PROCEEDINGS: Monday 24th September 2001 - Day 171

Dr. James Aubuchon gave evidence to the Tribunal. Dr. Aubuchon's career concentrated on transfusion medicine, including blood banking and immunohaematology. With regard to the screening of donors, Dr. Aubuchon described the meeting at the CDC in January 1983, which gathered experts from across the United States to discuss the apparent transmissibility of HIV through blood transfusion. At that time, no test capable of detecting the virus was available. The only way to screen donors was by of questioning to identify those donors who may have had exposure prior to donation to the HIV virus, in that they may have engaged in high risk activities. As time went on, questions became more specific and a greater number of questions were asked of potential donors. These systems amounted to a system of self-deferral.

By March 1985 a HIV antibody test was licensed by the Food and Drug Administration in the United States. Dr Aubuchon said that most blood centres in the United States had the test up and running within 30 days after its licensure in early March of that year. By the end of April 1985, virtually all blood banks had HIV testing in place. The BTSB did not introduce HIV testing until October 1985, by which time the Kilkenny health worker had become infected with HIV by way of blood transfustion. Dr. Aubuchon said it was policy in the United States that if a test tproved positive, the donor was notified. Dr. Aubuchon said that the notification began in the summer of 1985. There was a gap between the introduction of testing and the introduction of notification of positive tests to infected donors.

In the summer of 1986 a general policy of look-back was introduced. In this way, positive donations were tracked to ascertain if the donor had given previous donations. The look-back included all the components that came from a donation, including red cells, platelets, plasma and cryoprecipitate. If the plasma had been sent for fractionation, as opposed to being transfused in a hospital, that plasma was recalled from the fractionator.

Dr. Aubuchon said that in April and May of 1985, commercial test kits for HIV were available in the United States. Dr. Aubuchon said he could see no reason why HIV testing could not have been introduced generally in any blood bank in April and May of 1985.

With regard to the release of untested platelets, Dr Aubuchon said it was not unheard of that untested components would be released in emergency situations, but they would certainly strive not to release any untested products. If such untested products were released they were clearly identified as being untested to those who would use the products.

Dr. Aubuchon was cross-examined by Mr. Raymond Bradley for the I.H.S. and Mr. Clarke of the BTSB, who discussed the so-called magnet effect with Dr. Aubuchon.

PROCEEDINGS: Tuesday 25th September 2001 - Day 172

Today, Dr. Shelby Dietrich gave evidence. Dr. Dietrich worked for over 40 years as the Director of two Centres in the United States; the Orthopaedic Hospital, Los Angeles and the Huntington Memorial Hospital, Pasadena, California.

Dr. Dietrich said that she relied on the producers of factor concentrates and on the fact that they had been licensed by the FDA for assurances that the products were safe. She said that although the Centres she directed were the second largest users of blood concentrates in the US, in the early 1980s they were not aware of any allegations that some manufacturers had sourced blood plasma from prisons and from other high risk groups.

Dr. Dietrich said that the greatest difficulty between 1979 and 1985 with regard to AIDS, was the lack of information. She described the recommendations made by the World Federation of Hemophilia between 1979 and 1985 as being meaningless, and she attributed this to the lack of information. She said that, in particular, between 1983 and 1984 there was great uncertainty as to what was best for patients; as time went on she said uncertainty grew. The uncertainty only came to an end after the Autumn of 1984 when heat-treated concentrates proved to be effective in preventing the transmission of HIV. Dr. Dietrich described the periods between 1983 and 1984 as the blackest years of her professional career.

When asked about Hepatitis C infection, Dr. Dietrich said that the rate of HIV infection was so severe at that time that Hepatitis C seemed to be like a bad cold in comparison. She described the treatment policy in place as concentrate-on-demand. They would provide factor concentrates from whatever manufacturer was licensed to manufacture them. Cryoprecipitate wasn't an option in Los Angeles because of the high risk of infection in donor pools. Dr. Dietrich described how she had visited the donor centre of one factor manufacturer which was near the Mexican border. She had made this unannounced visit because of rumours that some companies were collecting plasma from high-risk groups. However, she said that she was pleasantly surprised by what she saw at the donor centre. She said she had read numerous allegations over the years that manufacturers were collecting plasma from prisons and other high risk areas in the United States. In general she said she avoided contact with drug companies who were keen to target doctors to increase sales of their product.

Dr. Dietrich was asked by Mr. Bradley for the I.H.S. about their programme for testing and informing patients of their HIV status. She described a system whereby as soon as the antibody tests became available, patients were tested and informed of the results within days. There was a special nurse who assisted in informing patients and counselling them after they had been informed of their status.

PROCEEDINGS: Thursday 4th October 2001 - Day 173

Dr. Don Francis gave evidence to the Tribunal. Dr. Francis worked at the Center for Disease Control in Atlanta, Georgia, from 1971 until 1992. Dr. Francis informed the Tribunal that the CDC is an agency of the United States Federal Government, dealing with public health and preventative aspects of infectious diseases and other public health problems.

In the early 1980s, Dr. Francis was part of a task force set up to deal with AIDS. The first cases of AIDS in the United States were reported in June 1981 in the CDC's *Morbidity and Mortality Weekly Report* (MMWR). The first cases of AIDS were reported from the Los Angeles area and were followed by reports from San Francisco, New York and Miami. The outbreak of the disease was investigated by the CDC. In the outset it was hypothesised at the CDC that the disease was caused by some sort of transmissible agent.

In 1982 HIV had spread to the heterosexual community. In July 1982 the first cases of AIDS in the haemophilia community were reported. Cases of PCP were reported in persons with haemophilia A. On July 27th 1982, the CDC convened a meeting at Washington DC which was attended by blood bankers, fractionators and other blood industry players. Evidence was emerging that the disease was infecting persons with haemophilia. At the time it was recommended that surveillance be expanded to those establishments collecting and distributing blood. A warning to fractionators from the CDC was issued in July 1982. The fact that there was a problem emerging through the use of blood and blood products was clearly at the disposal of the community of blood users in July 1982.

At the July meeting the topic of discussion was the fact that there was a new fatal disease in the US. The meeting was hastily gathered and the topic of discussion was the 300 cases of AIDS that were then known. The severity of the disease was noted. The thinking at the time was that if a person was infected with AIDS, the result was invariably fatal. As 1982 progressed, the cases of AIDS in persons with haemophilia doubled every six months. A further meeting was convened by the CDC in January 1983 under the auspices of the Public Health Service in Atlanta. The meeting looked at the modes of transmission from blood and blood products and at those who were becoming infected, such as persons with haemophilia and transfusion recipients.

In December 1982, the first blood borne transmission of AIDS to be confirmed, was reported upon the death of an infant in California. The infant had received a blood transfusion donated by a person with AIDS.

Dr. Francis described the meeting of January 4th 1983 as being unpleasant. The CDC wanted immediate steps taken to protect the recipients of blood and blood products. Fractionation industry participants at the meeting and industry officials preferred to wait and see. They wanted proof that the products they were putting into circulation were in fact spreading the disease. The meeting concluded that there were differing perceptions of:

1) The likelihood of AIDS is caused by a transmissible agent;
2) The risk of AIDS from blood donation, both whole blood and pooled plasma;
3) The best approach for establishing altered guidelines for blood donations, donor screening or testing, and donor restriction.

Dr. Francis indicated that while there were different perceptions, he was in no doubt that transmissions were associated with donations of gay men who donated their blood out of altruism, and from plasma

from gay men and former intravenous drug users who were selling plasma. The very simple intervention was to remove these donors from the collection process.

Given that plasma pools were inevitably contaminated with the AIDS virus, Dr. Francis was of the view that other methods of dealing with haemophilia should have been implemented, especially the use of cryoprecipitate. Dr. Francis described the January 1983 meeting as a defining moment in the threat of the AIDS virus.

There was no agreement as to the use of any surrogate testing and no agreement among haemophilia treaters as to how to react to the threat of AIDS in blood and blood products. Dr. Francis said the recommendations as a result of the meeting were unsatisfactory. Dr. Francis said that the use of anti-Hepatitis B core testing would have eliminated 75 per cent of AIDS donors. However, surrogate testing did not become CDC policy, and use of cryoprecipitate only did not become CDC policy.

The failure to remove infected donors from the donor population, and failure to seek an alternative to pooled plasma products, led to a disastrous situation, where in the United States, said Dr. Francis. Up to 30,000 persons were infected with AIDS by blood transfusion, and up to 10,000 persons with haemophilia were infected by pooled plasma products.

Dr. Francis said that at the January 4th meeting, he literally pounded the table and asked how many deaths they needed before they would respond.

Dr. Francis was referred to a joint statement on AIDS related to transfusion from the American Association of Blood Banks, the American Red Cross and the Council of Community Blood Centres, dated 13th January 1983. A major area of concern was whether attempts to limit voluntary blood donations by individuals from groups with a high prevalence of AIDS, were then appropriate. This question had medical, ethical and legal implications. Dr. Francis described this as an infamous document which set out the view of the blood and plasma industry - that very little should be done until there was proof that their products were indeed causing the problem. The strongest players in the debate favoured a minimalist approach to intervention. The strongest players were those representing the industry. However, those with the expertise as to the enormity of the risk, such as Dr. Francis in the CDC, did not get their message across. Dr. Francis said the expert view did not get to those who could do something about it. He said the real experts did not manage to get their message out.

Dr. Francis described the isolation of the HIV virus. Firstly, by the Institute Pasteur in May 1983, and then in early 1984 a publication by Gallo in March of that year, which revealed the cause of HIV to be a virus. When they identified the virus it was possible to identify those who were infected with it, not just those who were manifesting the symptoms of AIDS. Almost all persons with severe haemophilia were infected.

In the gay populations of cities such as San Francisco, about half were infected with HIV. The availability of the virus also meant that a test for the virus could be developed. Reliable tests became available in March 1985. While in March 1985 a commercial test for the HIV virus became available, Dr. Francis maintained that a surrogate test by way of Hepatitis B core testing, would have provided effective screening tests for blood donors. Dr. Francis said the Hepatitis B virus was essentially identical to the epidemiological picture of HIV. Sexually active persons, especially gay men and users of intravenous drugs and some other groups, are at high risk rates for Hepatitis B infection.

Dr. Francis said that at the January 4th meeting in 1983, data was presented that showed that 87 per cent of people with AIDS tested positive for Hepatitis B infection. On the other hand, less than 5 per cent of blood donors would test positive for Hepatitis B. Dr. Francis said that if those testing positive for

Hepatitis B were eliminated from the blood donation pool, HIV would also have been eliminated to the same extent. Dr. Francis said that if Hepatitis B core testing had been introduced in January 1983, upwards of 75 per cent of the transfusion related AIDS cases would not have occurred.

Dr. Francis was examined by Raymond Bradley for the Irish Haemophilia Society. With reference to the recommendation that high risk groups should be excluded from blood donation, Dr. Francis said that it was known that in March 1983 donor collection criteria were introduced. These criteria were designed to exclude high-risk donors. Dr. Francis said at the time, it was thought that fractionators and the plasma collectors would seek to eliminate high-risk donors, particularly members of the gay community. Dr. Francis said that it became clear subsequently that not only did the fractionators and plasma collectors fail to exclude high-risk donors, but there was an horrendous situation where gay donors were selected because they were Hepatitis B positive.

Fractionation companies were using the Hepatitis B antibodies for making gammaglobulin. And while the harvesting of Hepatitis B antibodies in this way was a legitimate exercise, companies, instead of disposing of the factor VIII fraction of these donations, added such fractions to their plasma pools. In this way, the companies concentrated the HIV virus into the pools from which blood products were made.

Dr. Francis said this was one of the major reasons why so many haemophiliacs around the world died. Dr. Francis said this information had only emerged in the last couple of years. He said that in addition to using the plasma fraction from Hepatitis B positive, and therefore HIV positive, gay men for the manufacture of factor VIII and factor IX, prison plasma was also used. Dr. Francis said prison plasma should not have been used because of the high incidence of IV drug abuse and homosexual sex in prisons.

Dr. Francis explained that the gammaglobulin part of the blood donation goes through a cold alcohol procedure to purify it. It is therefore safe for infectious agents. Dr. Francis said the fractionators and plasma collectors were selecting people with Hepatitis B and putting their donations into factor VIII. Such donors were the highest of high-risk donors, and their plasma donations were being used at a time when the policy was to exclude such high-risk donors from donating blood. Dr. Francis said if anyone knew that the fractionators were doing this, there would have been a total outcry, and this material would have been taken off the market completely at the time.

Dr. Francis said to take gay men who were Hepatitis B positive, and take their plasma and put it into factor VIII, was almost designed for infecting the recipients with HIV. Dr. Francis said he did not believe that the fractionators meant to infect their customers with HIV, but it was simply a matter of economics. More money could be made from the fractions by adding them to the pools from which factor VIII was made, and given an opportunity to make money the fractionators did not think through the incredible mistake that they were making.