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STANFORD UNIVERSITY SCHOOL OF MEDICINE  
J. Garretts Allen, M.D.  
Professor of Surgery

January 6, 1975

Dr. W. D'A. Maycock  
Blood Products Laboratory  
Lister Institute  
Elstree, Herts, England

FAO

Malcolm  
Chisholm

Dear Doctor Maycock:

It has been many years since I last corresponded with you. At this point, I would like to ask a question that deals primarily with Factors VIII and IX.

It is my understanding from Dr. Judith Pool that the only place where these two components are prepared in Great Britain is at Oxford. Am I correct in assuming that your laboratory does not produce them? No doubt you also know what the practices in Glasgow are at the West of Scotland Blood Centre, as I last knew it, then run by Dr. John Wallace. Do they produce Factors VIII or IX? I would appreciate a little information you can provide about the Lister Institute and the one in Glasgow regarding the preparation of these components.

Dr. Pool spent the past year at Oxford and tells me that at least one of the sources for commercial Factor VIII and IX is the Hyland Laboratories in the Los Angeles area. Dr. Biggs mentioned in her letter in LANCET, last June 29th, that there were two other commercial sources but Judy Pool did not know which they were or whether they were from the United States. As you know, Cutter's product Konyne, for Factor VIII deficiency, has proved extraordinarily hazardous, a 50 to 90 percent rate of icteric hepatitis developing from it. About half of these proved fatal. Cutter's source of blood is 100 percent from Skid-Row derelicts (Transfusion: May/June, 1974).

The other imponderable which has troubled most of us is the ineffectiveness in screening for the HB antigen (Transfusion: July/Aug 1973). This failure, of course, dates back to at least 1971, and suggests that half, if not more, of the cases of posttransfusion hepatitis are caused by an agent other than Hepatitis A or B. Whatever this agent(s) may be, it still seems to be more frequently encountered in the lower socio-economic groups of paid and prison donors. It is minimal among volunteer donors. It seems that the most certain method to have for reducing the number of carrier donors at the present time is still to determine whether or not the donor has been paid in money in reduction of his prison sentence.

A blood bank for these groups in the United States is a monetarily motivated establishment. The commercial blood banks attract these kinds of donors. Until we understand this problem better, I would hope Great Britain would give some thought to what the purchase of Factors VIII and IX from the United States tends to do to our attempts to have a volunteer program. Commercial blood banking perpetuates the high risk rates for hepatitis we encounter with their products, and it

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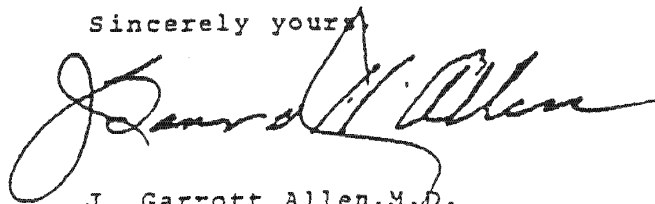
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tempts these same commercial firms to sell the residual products of these high risk donors (red cells, platelets, leukocytes, etc.) to non-immunized patients who tend to be more susceptible to post-transfusion hepatitis than is so far the non-virgin hemophiliac.

I would appreciate knowing the situation as it is in the U.K. Would you write to me about it?

Best wishes.

Sincerely yours,



J. Garrott Allen, M.D.

JGA:as

A check-out  
 World In Action documentary  
 1975 "Blood Money"  
 and note comments  
 from Dr John Watts  
 Scottish B.T.S. on  
 imported plasma!!!  
 from U.S.