Correspondence

ACP Broadsheet No 145—Investigation of patients with autoimmune haemolytic anaemia and provision of blood for transfusion

It is unfortunate that this ACP Broadsheet,1 published with the full authority of the Association of Clinical Pathologists, makes no reference to best practice, nor provides hospital blood banks with a workable protocol for investigating a patient with suspected autoimmune haemolytic anaemia. It is merely an account of the various techniques available for investigating a positive direct antiglobulin test (DAT), irrespective of the medical history, which would lead a clinician to suspect a warm or cold autoimmune haemolytic anaemia, and whether active haemolysis is present or not. There is no discussion about the clinical value of each test, or how the series of investigations described should be prioritised. Neither is guidance provided regarding which tests should be undertaken by hospital laboratories and at what point samples should be sent to a reference laboratory. The Broadsheet is based on the procedures used at one particular Blood Transfusion Centre and reflects local practices and individual prejudices.

Worryingly, there are numerous errors and misconceptions. For instance, the paper refers to genotyping, where it should state phenotyping: polyspecific AHG reagents need only contain anti-IgG anti-C3, as defined by the British and ISBT guidelines and the presence of other specificities, such as anti-IgM, is not mandatory. The abbreviation “LISS” only refers to the Moore and Mollison formula for low ionic strength solution which is not the reagent recommended for use with the Diamel gel direct antiglobulin test cards. The recommended solution for the gel test is a low ionic diluent supplied by the manufacturer with the LISS; the two preparations cannot be used interchangeably. Some of the described serological techniques are obsolete and in general do not follow those recommended in the current BCSH guidelines for hospitals, etc.

This complicated series of expensive tests, supposedly devised to investigate patients with autoimmune haemolytic anaemia, seems to be totally divorced from the reality of the internal market and meaningfull patient care. For instance, there is no clinical value in performing red cell eluates, except where the patient has recently been transfused. On the other hand, the importance of excluding underlying red cell alloantibodies, which may be masked by autoimmune antibodies, in the case of patients who are likely to need blood transfusion is not stressed. Furthermore, clinicians should be made aware that the allogeneic stimulus of blood transfusions sometimes exacerbates the autoimmune process and may also lead to the development of alloantibodies. For this reason, blood transfusion should be given only when there is a very strong indication.

Unfortunately an opportunity to provide much needed clear guidance to hospital laboratories for the investigation of a commonly encountered problem has been lost.


Drs Sokol, Booker and Stamps comment: We read with interest the comments made by Dr de Silva and colleagues on our Broadsheet, but as it is based on over 30 years experience of autoimmune haemolytic anaemia we stand by our views. It is helpful to have the thoughts of experienced colleagues as we can all learn from each other. The purpose of the Broadsheet was to make hospital blood banks aware of the range of investigations currently available and to help them overcome commonly encountered serological problems; it was never our intention to dictate to them which tests to carry out; the algorithm clearly shows which tests are considered more appropriate for specialist centres.

We are fully aware of the various transfusion serology guidelines and regard them as valuable indicators of minimum standards. In some term “broad spectrum” was chosen so that we could recommend a screening reagent for direct antiglobulin testing which contained an anti-IgA component (anti-IgM was not mentioned in this context). In the Guidelines for the Blood Transfusion Service (HMSO, 1994), “LISS” refers to a low ionic strength solution defined by pH, conductivity and osmolality; there is no mention of a particular formula; also, the abbreviation “LISS” is printed on the label of the Diamel diluted bottle. We would agree that the term phenotyping would probably have been more appropriate, and that whilst some techniques may be used less frequently, none can be considered obsolete.

In our experience, clinicians are fully aware of the potential antigenic stimulus of blood and only transfuse when necessary; the idea that patients with autoimmune haemolytic anaemia should be given blood only in the last resort is a myth. The importance of detecting alloantibodies in the presence of autoantibodies and the methods for doing so are well covered in 10 paragraphs of the Broadsheet.

Our major disagreement with the views of Dr de Silva and colleagues is in the value of red cell eluates. We feel that studies on eluates are extremely important in order to provide meaningful serological information; as clearly stated in the Broadsheet, it is wrong to assume that a positive direct antiglobulin test is solely due to autoantibodies or a delayed transfusion reaction. We need to be able to recognise the many patients who have an autoimmune haemolytic component within a very complex clinical situation, as well as investigating those suffering from frank idiopathic autoimmune haemolytic anaemia.

With regard to the internal market of which we are all acutely aware nowadays, the procedures described in the Broadsheet are extremely cost-effective, as well as keeping open the path of intellectual and scientific progress which results in a better service to patients.

Macroscopic examination of prostatic specimens

The recent ACP Broadsheet by Harnden and Parkinson1 is timely and welcome. It does, however, contain a small contradiction which I think should be corrected.

Dr Harnden and Parkinson comment: We thank Dr Furness for his thoughtful criticism of the recent Broadsheet and do not dispute his assertions concerning the mathematical theory of volume measurement. We were forward-thinking to see the details of the random sampling method that was used in the study, although we should perhaps have stressed this in our discussions.

The mathematical model to apply to the sampling of prostate chips is dependent on the fact that we are dealing with a specimen which itself is a sample already influenced by the variability of the clinical situation and the constraints of the operative procedure. We are aware that to randomise prostate chips in the laboratory, we would need to introduce a validated mathematical technique, such as a grid labelled with random

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doi: 10.1136/jcp.49.2.187-a

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