been at war (WWII) for 16 months. Although the value of blood transfusion therapy had long been established, equipment and supplies were still rudimentary and reagents practically nonexistent. In my training at this major city hospital, blood was typed only for ABO using serum pooled from the patients' samples from the previous day. Cells for reverse grouping (called back-typing) were chosen from samples from patients giving the strongest agglutination. Pasteur pipettes were used to deliver the serum and cells onto glass microscope slides; the contents were mixed with applicator sticks and the test was allowed to stand on the workbench for about 15 minutes. Compatibility testing consisted of a saline crossmatch on a slide which was allowed to stand 1 hour; drying was prevented by covering it with a Petri dish lid fitted with a moistened piece of filter paper. Typing and crossmatching was not done on the midnight shift; only group O blood was accessible to the medical interns if they needed to transfuse patients. Needless to say, in that situation no compatibility testing was done.

In 1944 when my training was over, I was hired to work in the laboratories of the Children's Hospital of Michigan. Here, we had one of the first sources of commercial ABO serum. It was packaged as dried granules in a piece of glass tubing 5 cm. long with a cork at each end; in the middle was a plug of cotton to separate the yellow-dyed serum from the blue-dyed serum at the other end. Toothpicks were supplied to measure out the amount of dried serum that would fit on the broad end of the stick. The pick was then used to stir the serum and whole blood or cells. No reverse grouping was done because it was thought that babies had not made their own alloagglutinins.

This lab was indeed fortunate in that as a children's hospital, babies with HDN were transferred in from all area hospitals. As a consequence, anti-Rh serum was obtained from the mothers and it was then utilized until commercial sources became available in the late '40s. In these early days, donor blood was obtained from relatives and friends of the patient. Donors were bled into 1 L glass bottles marked at the 500 mL level with a wax pencil; the anticoagulant contained therein was simply sodium citrate. Rubber tubing fitted with a 15-gauge donor needle was used to collect the blood that flowed by gravity into the gauze-stoppered bottle positioned on the floor below the donor bed. All of this equipment was reused after washing and steam sterilization. While this primitive equipment was soon replaced in the United States by commercially prepared vacuum bottles and plastic donor sets and then subsequently by the plastic bag, I saw donor equipment being reused in Moscow in 1964 and in Beijing in 1983!

In the viewpoint of laboratory personnel, the only “good” in the “good old days” was the freedom to collect all manner of samples from patients to investigate interesting anomalies without getting their consent!

Kay Beattie, MT(ASCP)SBB
20 Yacht Club Dr., Apt. 107
North Palm Beach, FL 33408

Blood Group System Terminology: Quick Reference

A number of years ago I read a clear and concise article on the current conventions of blood group terminology by Peter Issitt and Marie Crookston. At the time, being relatively new to the world of immunohematology, I needed all the help I could get. That was in 1984 and now it’s 1997. With recent mergers, consolidations, name changes within and between blood group systems, introductions of new systems, and fabulous new ways to name them all, I still feel I need all the help I can get!

Linda Issitt’s article, “Review and update: blood group terminology” (Immunohematology, Vol. 13, No. 1, 1997), is timely and has caused me to wonder how many more of us are “out there” when it comes to knowing current conventions for names of red cell antigens. In response, I offer a quick reference on blood group system terminology both for my own desperate need as well as a help to my blood banking colleagues.

I agree with Ms. Issitt that it is important to be consistent and correct in order to “effectively communicate in reports, letters, and manuscripts allowing for correct interpretation and comparison with other published works” and reported results. I hope my quick reference will lend itself toward that end.

Kirk D. Kitchen, MT(ASCP)SBB
Immunohematology Section
Blood Systems Laboratories
6220 E. Oak Street
Scottsdale, AZ 85252