The chapter on transfusion practices gives succinct descriptions of maximum surgical blood ordering; alternatives to allogenic transfusions; transfusion practices in particular situations (e.g., massive transfusion, obstetrics, and pediatrics), therapeutic apheresis, and administration of blood. The chapter on hemostatic disorders gives an overview of hemostasis and then gives a brief discussion of platelet disorders and congenital and acquired disorders of coagulation and fibrinolysis. The chapter on transfusion reactions has a handy table listing the types of reactions along with the signs and symptoms, treatment, and prevention. In addition, there is a concise table on the treatment of an acute hemolytic transfusion reaction. This will be particular helpful to the novice.

In these days of weighty specialty textbooks, this authoritative pocket guide serves as a handy resource for the clinician who transfuses patients. In particular, it should be recommended for those who desire quick information about transfusion medicine. Finally, this guide provides an up-to-date "quick read" for those physicians in training in all fields of medicine.

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COMMUNICATIONS

Letters to the Editors

Re: Gel technology for RhIG dosage

In the paper "A gel technology system to determine postpartum RhIG dosage" (Vol. 16, No.3, 2000; pp. 115–9), the authors (Fernandes JR, et al.) correctly identify a dilution of 20 µL of cord blood (packed to a hematocrit of 70 to 75%) into 10 mL of mock maternal blood (packed to a hematocrit of 70 to 75%) as representing an 0.2% fetomaternal hemorrhage. But, somehow, dilutions of 50, 70, and 100 µL into 10 mL are given as 0.4%, 0.56%, and 0.8%, respectively. Clearly, they actually correspond to 0.5%, 0.7%, and 1.0% (or 25 mL, 35 mL, and 50 mL of volume based on a maternal volume of 5000 mL). The interpretation for RhIG dosage cutoffs needs to be changed accordingly. It should also be noted that the AABB Technical Manual gives 30 mL of fetal whole blood volume as the recommended amount for coverage by 300 µL of RhIG as opposed to 20 mL as used by the authors.

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We thank Dr. Apfalroth for his observations. The issue of inocula percentages is noted. As indicated in our article on page 116, the percentages of 0.2, 0.4, 0.56, and 0.8 refer to the percentages corresponding to 10, 20, 28, and 40 mL of fetal blood in 5000 mL of maternal blood.1

While it is correct that the AABB Technical Manual states that 300 µg of Rh immune globulin (RhIG) is sufficient to counteract the immunizing effects of 30 mL of fetal whole blood, it has been advocated that if one used 300 µg of RhIG to cover for only 20 mL of fetal maternal hemorrhage, this would further decrease failures of immune therapy.2

In any event, critical to the use of this test is the concomitant use of calibrators to determine when adequacy of RhIG dosage has been met.

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