immunized by a unit of blood that would have been called D-positive prior to this change. Unless all centers have made the change, the accused center will not be able to claim “standard medical practice.” It will be a huge task to force all centers to stop testing to provide uniformity throughout the country. What about those that incur no extra cost in doing the test? Why should they change?

In summary, while I believe D− bloods, as defined above, are probably very poor immunogens, and it is extremely doubtful that continuing to test donor blood is justified, I also believe that we do not have sufficient scientific data on which to base the decision to stop testing donors for D+. Unfortunately, it will not be easy to gather more data like that in Dr. Schmidt’s paper. In addition, the emotional aspects of this issue are formidable, and it will require a great deal of effort to change this longstanding practice. Discussions like this are a good start.

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References

More on blood group terminology
To the Editor:

Hooray for John Case. In supporting John Judd regarding the use of anti-N not anti-N’ he does us all a favor. In fact, we do need a shorthand way of distinguishing anti-N that reacts visibly with N− red cells that have normal Ss SGP, from anti-N that does not. Visibly is the key word; all anti-N react with such cells and adsorption studies reveal the reactivity of anti-N that do not react visibly. At present, when writing about N and ‘N’, it is cumbersome to have to qualify the antibody each time anti-N is mentioned. However, as pointed out1,2, use of anti-N’ is not the answer to this terminology problem.

John Case is also correct in saying “...it is important that we do not allow ourselves to lapse into jargon, or adopt loose terminology that departs from established conventions.” Unfortunately, a statement later in his letter does exactly that. In the discussion, the serological reactions of antibodies with NS+/NS−, MS+/MS− and MS+/MS− cells, are described. MS− and NS− as used, are gene symbols that should not be used directly to describe red cells. The correct way of listing the cells would have been to describe them as being from individuals genetically NS+/NS−, etc. It is this type of misuse of gene symbols that has resulted in the widespread but incorrect use of terms such as “homozygous (or heterozygous) red cells.” Red cells do not have genes; further, the phenotyping tests that we use detect gene products or the products of gene products. As we have pointed out elsewhere,3 red cells come from homoygotes, heterozygotes or hemizygotes; they cannot themselves be any of those.

References

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In Memoriam

The editorial staff of Immunohematology extend their sympathy to Marie Crookston on the death of her husband, John Crookston, MD, PhD, FRPC(C), 1922–1987.

Dr. Crookston established the Blood Transfusion and Hematology Laboratories at Toronto General Hospital and the first postgraduate program in Canada for training physicians and technologists in Hematology. He retired in 1987, after making a major impact on teaching, blood transfusion, and hematology in Canada.