COMMUNICATIONS

From the Editor:

The editors of *Immunohematology* are grateful to Ortho Diagnostics Systems, Inc., for its generous contribution in support of the publication of this issue.

Ortho is a leading worldwide manufacturer of reagents for the blood bank. They have a history of leadership in the blood bank field, including development of monoclonal antibodies for blood grouping and Rh immune globulin. In addition, Ortho has a tradition of supporting educational endeavors in the field of blood banking.

We thank Ortho Diagnostic Systems, Inc. for its continuing support.

Red Cross recognition of and appreciation for such donations in no way represent Red Cross endorsement of any company or product.

Dolores Mallory
Editor-in-Chief

From the Managing Editor:

SI units (*Système International d'Unités*), an outgrowth of the metric system, represent an attempt to establish a uniform style for the interchange of clinical and laboratory data.

In April 1990, the Editor of *Transfusion* requested that all material submitted for consideration for publication relate laboratory and clinical data in both traditional and SI units. Publication of papers in *Transfusion* using traditional and SI units will begin in January 1991 for a 1-year assessment.

In this issue of *Immunohematology*, the author of “Two cases of autoantibodies that demonstrate mimicking specificity in the Duffy blood group system” has used both traditional and SI units for laboratory data. I believe this is the first paper I have received for publication consideration that included this addition.

The editors of *Immunohematology* do not require, but would welcome, the use of traditional laboratory data followed by SI units.

I refer all who are interested in the history and references for SI units to *Transfusion* 1990;30:6. On pages 70–90 of that issue, there is a complete listing of SI units for clinical laboratory test results.

Mary H. McGinniss
Managing Editor

To the Editor:

I was interested to read the tech tip in *Immunohematology* 1990;6:73–4, which suggests a simple method for the removal of contaminating white cells prior to serological procedures. We, too, have encountered the problem of “gelling” in samples from chronic lymphocytic leukemia (CLL) patients with excessively high white cell counts. In our laboratory the problem occurred when the samples were treated by a low pH solution as part of a routine glycine HCL elution procedure.

In a similar study we looked at separating blood samples on lymphocyte separation medium (LSM) for the removal of contaminating white cells. (Storry JR, Carter LS, Poole GD. Leucocyte contamination in CLL patients with acquired AIHA causing problems in acid elution and auto absorption. 7th Annual Meeting, BBTS (poster). September 1989, Durham, England.) LSM is routinely used in HLA laboratories for the separation and harvest of lymphocytes for tissue typing. The red cells are separated by density, a process facilitated by rouleauxing of the cells by Ficoll. There is no loss of red cells and the Ficoll is easily washed off, leaving them leukocyte poor and ready for use. In our study we separated anticoagulated whole blood on an equal volume of LSM, centrifuging the tube @ 400 g for 15 minutes. (If plasma is required, this can be separated prior to the procedure and the cells diluted to 50% in 0.9% sodium chloride.) We looked at samples from seven patients—six were diagnosed as having CLL, one as having acute myelogenous leukemia (AML)—and at white cell concentrates prepared from normal donors. The white cell counts ranged from $13.1 \times 10^6/\mu L$ to $188.8 \times 10^6/\mu L$. We also determined a level below which gelling does not occur routinely. By our method this was established as $50 \times 10^6/\mu L$.

LSM provides another quick, easy, and inexpensive solution to this frustrating, if infrequently encountered, problem.

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