To the editor:

Low-dose versus high-dose therapy for Gaucher disease: goals and markers

Zimran et al state in their commentary1 that the title of our study2 is misleading because the superior effect of a high dose of imiglucerase compared with a low dose is “limited to the response of 2 surrogate markers, serum chitotriosidase and MRI scanning of the marrow.”7 We agree that no superiority of the higher dose was established with respect to the most widely used parameters of disease (ie, cytopenia and organ volumes), although subtle differences may not have become apparent due to the limited number of matched pairs for each parameter. In fact, we have shown in the past that one ninth of the originally established dose leads to apparently this finding has aroused a discussion that hopefully will stimulate a critical evaluation of clinical and biochemical markers against predefined goals of therapy.

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References


Response:

Correlation between Gaucher disease clinical severity and surrogate markers is weak

We are in agreement that the role of surrogate markers in the treatment of Gaucher disease requires further critical examination. We also agree with Hollak et al that there are several aspects of serum chitotriosidase levels that make this parameter a promising surrogate for disease severity. The high levels found in Gaucher disease and the fact that Gaucher cells secrete the enzyme make
neonates achieved platelet counts higher than 40/\mu L and more than 24 of these neonates with anti–HPA-1a–mediated NAIT treated with ran-.

dable strategy for the management of severe index cases of NAIT concluded that random donor platelet transfusion is an accept-

able treatment in neonatal alloimmune thrombocytopenia (NAIT). The authors describe the outcome of 27 neonates with anti–HPA-1a–mediated NAIT treated with random donor platelet transfusions. They found that 24 of these neonates achieved platelet counts higher than 40 \times 10^9/L and concluded that random donor platelet transfusion is an acceptable strategy for the management of severe index cases of NAIT before compatible platelets are available.

While we agree with this conclusion, we wish to stress that antigen-negative platelets are the treatment of choice for NAIT. The National Blood Service in England provides HPA-1a/5b–negative platelets for immediate treatment of neonates with a presumptive diagnosis of NAIT. We have compared the platelet counts and clinical outcome in neonates with anti–HPA-1a– and anti–HPA-5b–mediated NAIT transfused with HPA-1a/5b–negative platelets (ie, antigen-compatible transfusion [AC-Tx]) versus random donor platelet transfusion (R-Tx). In many cases of NAIT, a spontaneous recovery in platelet count is seen, and some are apparent in the study of Kiefel et al (eg, cases 1, 4, and 9). In such cases, it is difficult to be sure of the contribution of the transfused platelets to the increase in platelet count; we have therefore excluded such cases from our calculations (Figure 1; Table 1).

Figure 1. Mean platelet increments in neonates with NAIT following HPA-1a/5b–negative platelet transfusions or random donor platelet transfusions. The mean platelet increments in neonates with anti–HPA-1a– and/or anti–HPA-5b–mediated NAIT following HPA-1a/5b–negative platelet transfusions (n = 29) (open circles) or random donor platelet transfusions (n = 9) (closed squares) are shown. The error bars represent the standard deviation of the measurements. The dotted curves represent the fitted exponential decay curves to the data. The individual patient data are given in Figure 2.

To the editor:

**Platelet transfusion in neonatal alloimmune thrombocytopenia**

We read with interest the article “Antigen-positive platelet transfusion in neonatal alloimmune thrombocytopenia (NAIT)” by Kiefel et al. The authors describe the outcome of 27 neonates with anti–HPA-1a–mediated NAIT treated with random donor platelet transfusions. They found that 24 of these neonates achieved platelet counts higher than 40 \times 10^9/L and concluded that random donor platelet transfusion is an acceptable strategy for the management of severe index cases of NAIT before compatible platelets are available.

While we agree with this conclusion, we wish to stress that antigen-negative platelets are the treatment of choice for NAIT. The National Blood Service in England provides HPA-1a/5b–negative platelets for immediate treatment of neonates with a presumptive diagnosis of NAIT. We have compared the platelet counts and clinical outcome in neonates with anti–HPA-1a– and anti–HPA-5b–mediated NAIT transfused with HPA-1a/5b–negative platelets (ie, antigen-compatible transfusion [AC-Tx]) versus random donor platelet transfusion (R-Tx). In many cases of NAIT, a spontaneous recovery in platelet count is seen, and some are apparent in the study of Kiefel et al (eg, cases 1, 4, and 9). In such cases, it is difficult to be sure of the contribution of the transfused platelets to the increase in platelet count; we have therefore excluded such cases from our calculations (Figure 1; Table 1).

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