CORRESPONDENCE

To the Editor:

My moral sensitivities were somewhat jolted when I read the article by Eyster et al. (Blood 58: 719–723, 1981) concerning the bleeding time in hemophilia. It is well known that the hemostatic plug that eventually forms when a hemophiliac cuts himself accidentally is easily dislodged, producing so-called delayed bleeding. To subject 74 hemophiliacs to intentional significant trauma by the performance of template bleeding times seems to me to be morally unjustifiable. The risk–benefit ratio does not seem to warrant the performance of bleeding times in hemophiliacs, even with informed consent.

Fred Rosner, M.D., F.A.C.P.
Queens Hospital Center Affiliation of the Long Island Jewish-Hillside Medical Center Jamaica, N.Y. 11432

To the Editor:

Rebleeding that did not respond to direct pressure occurred in only a few patients. In each instance, bleeding ceased promptly with a single routine infusion of factor VIII (or IX), usually given at home.

We have continued to perform bleeding times on hemophiliacs when indicated clinically and have experienced no significant problems when firm pressure is applied and the area is covered for 24–48 hr following the procedure to prevent dislocation of the platelet plug.

M. Elaine Eyster, M.D.
Associate Professor of Medicine
Chief, Division of Hematology
Milton S. Hershey Medical Center
Pennsylvania State University
Hershey, Pa. 17033

To the Editor:

A recent report in Blood has documented the efficacy of utilizing lithium in a patient with Felty's syndrome to raise the circulating granulocyte count to an acceptable level to allow for the initiation of cytotoxic cancer chemotherapy. The proportion of patients with Felty's syndrome who benefit from lithium therapy is not clear. A number of single case reports have been published.1–3 In one series of 8 patients, all responded to treatment.4 Two patients then treated, based on this report, did not have any increment in the granulocyte count nor in the infectious complications related to granulocytopenia.5 Both patients treated had significant neuropsychiatric side effects. In another series of 3 patients, a significant elevation of the granulocyte count occurred with a dose of lithium at 900 mg/day.6 In the present series, 5 patients with Felty's syndrome were treated with lithium, 300 mg t.i.d. for 1–4 wk (Table I). Therapeutic levels were achieved. None of the patients had previously undergone splenectomy. Two patients were treated to allow for the use of subsequent cytotoxic agents for symptomatic arthritis; 3 patients were treated for recurrent infections. Patient 1 had full recovery of peripheral blood and bone marrow findings. Two patients (2 and 3) did not respond within 1–2 wk, and treatment was discontinued because of toxicity. Patient 4 did not significantly respond but has not had any toxicity and continues on therapy. Patient 5, whose total WBC rose on lithium therapy, had clinical resolution of recurrent skin infections, but the peripheral granulocyte count and the maturation arrest in the marrow have remained unchanged. These data suggest a spectrum of effects of lithium therapy in patients with Felty's syndrome. Full hematologic recovery did not occur universally in this series, and clinical improvement was noted in one patient without an increment in the granulocyte count nor in the marrow findings. Toxicity was noted and necessitated the discontinuation of treatment in 2 patients. The effects of lithium therapy on individual patients may not be predictable and treatment should be considered with care. A larger (cooperative) series may be needed to assess the usefulness of lithium in Felty's syndrome to reduce the incidence of recurrent infections and/or to allow for the use of cytotoxic therapy in patients with rheumatoid arthritis.

Fred Rosner, M.D., F.A.C.P.
Queens Hospital Center Affiliation of the Long Island Jewish-Hillside Medical Center Jamaica, N.Y. 11432

Delvyn C. Case, Jr., M.D., F.A.C.P.
Division of Hematology
Department of Medicine
Maine Medical Center
Portland, Me. 04102

REFERENCES

Utilizing lithium in a patient with Felty's syndrome [letter]

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