either 1 patient at 1 month and 9 months after BMT, respectively, still exhibited the M-bcr rearrangement.

We conclude that mRNA extraction for diagnosis of the bcr-abl rearrangement in CML from dried blood spots on filter paper is feasible. Filter papers enclosed in transparent storage sleeves may easily be filed with the patient’s records and thus allow comfortable access to DNA and RNA specimens collected at the time of diagnosis or during regular follow-up examinations for prolonged periods of time. In conclusion, simple spilling blood on filter paper may (1) facilitate the cooperation between laboratories and hospitals separated by long distances, (2) save transportation costs, and (3) contribute to standardize diagnostic procedures on a molecular level in CML and related diseases.

REFERENCES


Mismatched Platelet Transfusions to Alloimmunized Patients

To the Editor:

The recent report by Hussein et al.1 was of great interest to physicians who deal with patients who are alloimmunized and require support with platelet transfusions. It is often difficult or impossible to find perfect matches for all four HLA antigens. The investigators described considerable success using one antigen-mismatched platelet transfusions (OAMPT).

From the methods as presented, it is difficult to determine whether, in the practice of the investigators, these single antigens were unselected and random or whether there was a selection process for them. In many centers, it would be common to select antigens that are cross-reactive with those of the recipient, an approach originally described by Duquesnoy et al.2 In another approach, an antigen is avoided if lymphocytotoxic antibody testing indicates that the patient has antibody against that antigen.3,4 The investigators’ results would not be surprising if either or both of these strategies were consistently used.

It would be helpful if the investigators would clarify these points so that their results will more useful to physicians dealing with these patients.

REFERENCES


Response

To the Editor:

We agree with Dr Murphy that careful selection of donors mismatched for cross-reactive antigens and avoidance of donors with antigens against which recipient antibody is directed can favorably influence the results of one antigen mismatched platelet transfusions.

Because of this, in Table 2 of the report, we described the results of 211 transfusions, which included donor-recipient pairs that had been used only once, donors not mismatched for HLA B1 or its splits, were not mismatched for any known strong cross reactive antigen groups, and given to patients without lymphocytotoxic antibody against the
Responses of Granulocyte Colony-Stimulating Factor–Mobilized Peripheral Blood Mononuclear Cells to Alloantigen Stimulation

To the Editor:

We have been much interested in the recent report by Mielcarek et al1 that proposed one of the mechanisms explaining the unexpectedly low incidence of acute graft-versus-host disease (GVHD) after allogeneic peripheral blood stem cell transplantation (PBSCt) despite large numbers of T cells infused. They showed that T-cell proliferative responses to alloantigen stimulation were suppressed after granulocyte colony-stimulating factor (G-CSF) administration by a large number of monocytes in apheresis products. We also investigated alloantigen-stimulated immune responses of G-CSF–mobilized peripheral blood mononuclear cells (PBMCs) from normal donors using a mixed lymphocyte culture system. PBMCs before G-CSF administration (pre–G-CSF) and samples from leukapheresis (post–G-CSF) were obtained from six donors. Adherent
Mismatched Platelet Transfusions to Alloimmunized Patients

Scott Murphy