Correspondence

Table 1. Detection of Antibodies to Fasciola and Anisakis in Patients With DLBL

<table>
<thead>
<tr>
<th></th>
<th>AIVL</th>
<th>DLBL Other Than AIVL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (mean)</td>
<td>44-75 (65 yr)</td>
<td>49-78 (60 yr)</td>
</tr>
<tr>
<td>Male:female</td>
<td>3:2</td>
<td>10:9</td>
</tr>
<tr>
<td>Anti-Fasciola IgG</td>
<td>4/5†</td>
<td>1/19*</td>
</tr>
<tr>
<td>Anti-Anisakis IgE</td>
<td>3/5†</td>
<td>7/19*</td>
</tr>
</tbody>
</table>

Abbreviations: AIVL, Asian variant of intravascular lymphomatosis; DLBL, diffuse large B-cell lymphoma; NS, statistically not significant.
*Patients with positive results (3.0 SD or more for anti-Fasciola IgG, and 0.70 kU/L or more for anti-Anisakis IgE)/total number of patients.
†According to the continuously adjusted $x^2$ test and $P = .0021$ according to Fisher’s exact test (two-tailed).

Anisakis, known as the sushi worm, is a tissue-penetrating nematode that causes acute zoonoses and may be a cofactor of gastric cancer. It is noted that the geographical distribution of these helminth infections covers Asia. Further investigation of the association of AIVL with the infections of Fasciola, Schistosoma, or Anisakis may contribute to elucidation of the pathogenesis of AIVL.

Acknowledgment

We thank Prof Moriyasu Tsuji (Kyorin University, Tokyo, Japan) for helpful comments.

Takuhei Murase
Department of Hematology
Kazuhiro Tashiro
Department of Pathology

REFERENCES


Difficulties in Determining Prophylactic Transfusion Thresholds of Platelets in Leukemia Patients

To the Editor:

It was recently pointed out that platelet transfusion thresholds of 10,000 platelets/µL, as opposed to 20,000/µL, reduce platelet transfusions by approximately 20% in leukemia patients without increasing any major risk of bleeding. Others have suggested that an even lower threshold of 5,000 platelets/µL, as opposed to 20,000/µL, reduce platelet transfusion are presently caused by (1) the technical insufficiencies of conventional automated blood analyzers and (2) the existence of platelet-derived microparticles (or membranes) that can improve hemostasis. Without any consideration of these factors, determining platelet transfusion thresholds may remain costly guesswork.

(1) Most instruments used in laboratories to establish the platelet count do not recognize platelets but are only capable of counting particles within a defined size limit. Therefore, microcytic erythrocytes, schizocytes, cell debris, air bubbles, chemical precipitates, etc, mingle with electronic noise and true platelets, which, especially at low platelets levels and in the case of drug-induced leukemic cell destruction, can cause major errors in platelet counting. Rebulla et al. authors of a recent study, who chose a prophylactic transfusion level of 10,000 platelets/µL and not the lower 5,000 platelet/µL threshold, admitted doing so mainly because they could not trust the accuracy of platelet counts at low levels in automated blood analyzers.

We have shown in the past that the use of fluorescent platelet-specific antibodies (ie, anti-CD61, anti-CD41, or anti-CD42b) and multiparameter flow cytometry in establishing platelet counts can bypass the problems most blood analyzers have at low platelet levels. Immunodetection of cells/platelets with flow cytometry is no longer an elusive method but is part of everyday routine in many laboratories. Manufacturers of automated blood analyzers have recognized this new trend and are starting to integrate the immunodetection of cells/platelets into their routine repertoire. This will hopefully improve the accuracy of automated platelet counts in the future.

(2) Perhaps as important as the accurate enumeration of platelets is the identification of platelet-derived microparticles that fall below the normal platelet size-threshold of approximately 2 fL. In a survey of 14 patients with acute myelogenous leukemia receiving myelotoxic chemotherapy, we observed that the levels of platelet-derived microparticles (defined as the percentage of CD61^-/CD42b^- particles smaller than 2 fL; Fig 1) in the same patient may vary from near 0% to 76% of the total platelet events. Levels of microparticles in normal controls (n = 10) ranged from 0.4% to 7.9% (mean, 4.8%). At the time of diagnosis, the percentage of microparticles often distinctly increased (up to 13-fold)
The Italian Experience on Interferon as Maintenance Treatment in Multiple Myeloma: Ten Years After

To the Editor:

The role of interferon maintenance treatment in patients with multiple myeloma (MM) is still debated. In 1990, the Italian Multiple Myeloma Study Group published the results of the first randomized study on the role of interferon α2b (IFN) as maintenance treatment in patients responding to induction therapy.1 One hundred one MM patients responding to traditional first-line induction chemotherapy were randomized to receive (n = 50) or not receive (n = 51) IFN maintenance. Patients were recruited from a group of 202 symptomatic MM patients observed in the three university institutions of Rome, Bari, and Turin, Italy. The results originally demonstrated that a maintenance treatment with IFN prolonged response and survival duration in patients with MM who have responded to conventional induction therapy.

After this experience, five large randomized studies were published comparing IFN maintenance versus untreated control: two of them did not demonstrate any advantage as for response and survival duration; and two demonstrated a significant improvement both in response duration and in survival duration.2,3

The updated results of the Italian study 9 years after the randomization of the last patient confirm a significant prolongation of response duration in IFN maintained patients: the median response duration (from time of randomization to maintenance treatment) is 24 months in patients receiving IFN and 13 months in untreated patients (P = .0016). The results in terms of prolongation of survival are less significant: the median overall survival is 50 and 39 months, respectively (P = .21); among patients who had an objective response to induction chemotherapy (>50% reduction in M protein), the median survival was 50 and 35 months, respectively (P = .07; Fig 1). However, 9 patients are still alive and in response in the IFN-maintained group versus 2 in the unmaintained group.

In conclusion, the majority of randomized studies on IFN maintenance in MM as well as our results demonstrate that IFN maintenance significantly prolongs the response duration phase in MM patients responsive to previous induction therapy, whereas the efficacy on survival
Difficulties in Determining Prophylactic Transfusion Thresholds of Platelets in Leukemia Patients

Wolfram Springer, Alexander von Ruecker and Roswitha Dickerhoff