Letters and comments

Contributors to this section are asked to make their comments brief and to the point. Letters should comply with the instructions to authors at <http://www.rcseng.ac.uk/publications/annals/authorinstructions.html>. Tables and figures should only be included if absolutely essential and no more than five references should be given. The editor reserves the right to shorten letters and subedit contributions to ensure clarity.

COMMENT ON

doi 10.1308/003588408X301091

H Malik, H Bishop, J Winstanley. Audit of blood transfusion in elective breast cancer surgery – do we need to group and save pre-operatively? *Ann R Coll Surg Engl* 2008; **90**: 472–3

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A case in point

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Together with my wife, we read this article on the cost that might be saved by not performing group and save prior to elective breast cancer surgery. She had just had elective breast cancer surgery.

She was having completion left mastectomy and right mastectomy following previous lumpectomy with sentinel node biopsy (November 2007) and subsequent level 2 left axillary clearance surgery (December 2007) for a grade 3 left breast cancer 1.5 cm with one micrometastasis and one metastasis confirmed in the axilla. ER and PR were both strongly positive, Herceptin negative.

She completed 4 cycles of Epirubicin and 2.5 cycles of 4 scheduled of CMF complicated by *Mycobacterium chelonae* infection of her Hickmann line causing a severe atypical pneumonia. She was on a 3-month course of clarithromycin following on initial clarithromycin/ciprofloxacin/meripenem/linezolid by infusion which brought rapid improvement in condition, as species were resistant to all except clarithromycin.

Her tumour had arisen in an area of previous irradiation fields for Hodgkin's lymphoma treated in her early 20s (she had 4 relapses). She had been under follow-up in the local

MR breast scanning screening programme started for long-term Hodgkin's survivors but sadly her lesion was not identified and she found the lump herself.

At 6 h postoperatively, she had severe sudden haemorrhage with blood pressure dropping to 60/? and tachycardia of 120 requiring return to theatre. She was transfused with two units of irradiated blood of her own blood group (as previously grouped and saved) and had a further unit of irradiated universal donor blood. She had only recently found out re TA-GvHD from *Lymphoma Matters* (quarterly newsletter from the Lymphoma Association, Issue 74, Summer 2008) and also having come across the NHS leaflet *Information for patients needing irradiated blood*. (Blood for Hodgkin's disease patients is irradiated to prevent the life-long risk of graft versus host disease.)

We were grateful for the rapidity of response of her surgical team and the availability of blood, otherwise her outcome may not have been so good. We would disagree with the assertion that money can be saved by not doing group and save for patients for elective breast cancer surgery as potentially losing the life (or having a significant hypotensive complication) of a comparatively young patient for lack of transfused blood would easily involve the clinicians/hospital involved in expensive litigation!

AUTHORS' RESPONSE

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It is very difficult in any audit to cover all eventualities; clearly, the case cited is slightly unusual in relation to background history. Our comments and observations were really intended to apply to the vast majority of patients who have no history which might otherwise predispose them to either a bleeding tendency or to problems with transfusion. Clearly, if one exists it would be prudent to take precautions particularly if it was known that there were potential difficulties with obtaining a satisfactory cross match.