Haemochromatosis: Red Cross Blood Service policy

Margaret L Buring
Leader, Medical Services for Donor Related Issues, Australian Red Cross Blood Service Queensland, PO Box 10325, Adelaide Street, Brisbane, QLD 4000.
mburing@bigpond.net.au

To the Editor: The Australian Red Cross Blood Service (ARCBS) introduced a national policy for therapeutic venesection in December 1999 which allows the collection of blood from people with haemochromatosis. There is no charge for this service.

The policy outlines the principles under which ARCBS provides a therapeutic venesection service, conditions of management of the donors and the acceptability of the donations for clinical use.[1] These conditions are:

- The patient's condition benefits from regular venesection and the patient does not have a transfusion-transmissible disease.
- The blood donation will be used in clinical or derivative products only if the donors fully meet the donor selection guidelines for clinical use.
- Responsibility for patient management remains with the referring physician.
- ARCBS is responsible for the collection and for ensuring donor safety during the procedure. We will liaise with referring physicians about the venesection protocol if necessary, and reserve the right to refuse to venesect if there is a concern for donor safety.

A diagnosis of hereditary haemochromatosis (evidence of iron overload together with appropriate genetic studies[2]) is required before patients are accepted into the therapeutic venesection program.

Contact your local ARCBS for copies of the therapeutic request form. Completion of this will facilitate the entry of people to the ARCBS therapeutic program.

The full policy can be obtained from our website <www.arcbs.redcross.org.au>.

1. Sanchez AM, Schreiber GB, Bethel J, et al. Prevalence, donation practices and risk assessment of blood donors with hemochromatosis. *JAMA* 2001; 286: 1475-1481.
2. Vautier G, Murray M, Olnyk JK. Hereditary haemochromatosis: detection and management. *Med J Aust* 2001; 175: 418-421.

An ecological perspective of cholesterol

Christopher H Cantor
Psychiatrist, PO Box 1216, Noosa Heads, QLD 4567.
cantor98@powerup.com.au

To the Editor: The *Lipid management guidelines — 2001* supplement[1] is no doubt full of cardiovascular wisdom. Unfortunately, the authors appear oblivious to the fact that people are more than just cardiovascular systems. I found no mention of the risks of violent deaths associated with low cholesterol levels, which in some studies have been found to offset the decreased cardiovascular mortality benefits.[2]

In 1995, Engstrom et al neatly reviewed the relevant issues for those interested in populations of whole people.[1] They cite studies which found low cholesterol levels to be associated with homicidal offenders with habitual violent tendencies when under the influence of alcohol, boys with aggressive conduct disorder, and criminals with antisocial personality, as well as with increased depressive symptoms in men aged 50–89 years. Further, an evaluation of six primary prevention trials found a significant increase in violent deaths in groups receiving interventions to reduce serum cholesterol levels.[2]

Engstrom et al also reviewed studies which found increased aggression in cynomolgus monkeys fed a low-fat diet.[1] This appeared related to reduced serotonin activity, as serotonin is widely known to reduce aggression. In fairness, Engstrom and colleagues also cited studies which have not found an association between low cholesterol levels and aggression.[1]

If the increase in violent deaths associated with changing the dietary habits of whole populations turns out to be more than a red herring, the ethical and financial implications will be staggering. This evidence is not so conclusive as to have made me change my own relatively low-fat diet, but they do make me wonder if my irritation about the oversight in the *Lipid management guidelines — 2001*[1] might have something to do with my low fat intake!

1. Lipid management guidelines — 2001. *MJA* 2001; 175 (Suppl 5 November): S57-S88.
2. Muldoon MF, Mannuck SB, Matthews KA. Lowering cholesterol concentrations and mortality: a quantitative review of primary prevention trials. *BMJ* 1990; 301: 309-314.
3. Engstrom G, Alsen M, Regnell G, Traskman-Bendz L. Serum lipids in suicide attempters. *Suicide Life-Threat Behav* 1995; 25: 393-400.

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