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Practice Guidelines and Treatment of Patients with von Willebrand's Disease

To the Editor:—The Task Force on Blood Component Therapy of the American Society of Anesthesiologists is to be congratulated on the recent publication of "Practice Guidelines for Blood Component Therapy."[1] Unfortunately, recommendations concerning the use of cryoprecipitate in patients with von Willebrand's disease fail to incorporate recent evidence demonstrating the greater efficacy and safety of virally inactivated factor VIII concentrates in this setting.

Von Willebrand's disease represents the most common of the inherited bleeding disorders, with a prevalence as great as 1% of the population.[2] Subtypes of this disease are characterized by quantitative and/or qualitative abnormalities of von Willebrand factor, a plasma protein essential to platelet adhesion and the stabilization of factor VIII. Although DDAVP (desmopressin acetate) provides effective therapy in some patients with von Willebrand's disease, the response is unpredictable, frequently limited, and contraindicated in certain subtypes of the disease. Selection of the most appropriate therapy requires identification of the specific subtype of von Willebrand's disease present.

Administration of cryoprecipitate has been the traditional approach to management of bleeding in the patient with von Willebrand's disease unresponsive to DDAVP; however, more recent evidence demonstrates that select factor VIII concentrates provide a more efficacious and safe source for replacement of von Willebrand factor. Both the United Kingdom Regional Haemophilia Centre Directors and the Association of Hemophilia Clinic Directors of Canada have recommended the administration of virally inactivated factor VIII concentrates in preference to cryoprecipitate in the management of patients with von Willebrand's disease.[3,4] In comparison with other factor VIII concentrates, Humate-P (Armour Pharmaceutical, Kankakee, IL) contains the highest concentrations of von Willebrand factor antigen and activity and has been recommended as the treatment of choice in managing patients with von Willebrand's disease unresponsive to DDAVP.[5,6] The virally inactivated factor VIII concentrate Humate-P offers a safer, more efficacious approach than cryoprecipitate to management of the patient with von Willebrand's disease unresponsive to DDAVP. We suggest that the "ASA Practice Guidelines for Blood Component Therapy" be modified to incorporate recommendations concerning this recent advancement in the management of patients with von Willebrand's disease.

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In Defense of Waters, Blalock, and Taylor

To the Editor:—We applaud the recent article[1] that highlights the career of Dr. Lamont, a frequently overlooked figure whose major contributions followed a pattern learned from his mentor, Ralph Waters. The Waters model for an academic department of anesthesiology required that four basic criteria be met to facilitate successful developments as they were seen at the University of Wisconsin in Madison from 1927 to 1948. First, surgeons had to support the anesthesiologists' efforts. Second, support of the basic scientists was needed, including a willingness to collaborate on research efforts of mutual interest. Third, residents and medical students had to be available for instruction and introduction to clinical anesthesia. Finally, financial support for research and adequate staff was necessary.[2] These were the principles shared by Waters with his resident group, which included Lamont and Dripps.

During Lamont's struggles at Johns Hopkins, Blalock was initially supportive of the intent to build a program on the Wisconsin model. In a letter to Waters dated February 9, 1946, Lamont wrote about a letter of resignation he had been about to send to the University Board. Having sent it first to Blalock for comment, Lamont informed Waters that Blalock said "Please don't. I'm sure the University will accept your proposals. As for the money, you can have $10,000 from the University for Anesthesia tomorrow. Please give us a little more time."* Two months later, the situation changed, and Lamont was denied the funding and the additional staff necessary to move toward an academic program. Blalock was a member of the committee that recommended against Lamont's proposals.† Where Blalock stood on these issues remains unclear. However, Lamont's letters tend to argue against a flat refusal of Lamont's proposals by Blalock.[1]

The history of the Department of Anesthesia at the Hospital of the University of Pennsylvania is a bit more complex than suggested by Murvachick and Rosenberg. The brief mention of Ivan Taylor is somewhat misleading and a bit unfair. Taylor had a full 3-yr residency with Waters and Rovenstine, and a subsequent 2-yr experience as a departmental staff member with Waters at the Wisconsin General Hospital. When appointed at the University of Pennsylvania as the first physician anesthesiologist, Taylor came, in September 1938, into a most unfavorable situation in an institution where inhalation anesthesia had been in the hands of nurse anesthetists for 30 yr. He was caught in a situation where only one of several surgeons, I.S. Ravdin, offered full support. Taylor had a large clinical load to shoulder, as well as being the sole supervisor of nurse anesthetists and teacher to medical students and interns. He was frustrated by not having sufficient time and support for research activity. The Board of Managers for the hospital further complained that anesthetic fees had not increased sufficiently to justify an increase in the anesthesia budget.[3] Taylor stayed at the University of Pennsylvania for nearly 3 yr, hoping things would improve, but when he received a better offer from Wayne State University, he took it.

During World War II, Dripps threatened to leave the Anesthesiology Department at the University of Pennsylvania. It was in a series of letters between 1941 and 1944 that Ralph Waters counseled Dripps to be patient, that manpower would be more than sufficient after the war.‡ Dripps, during the war, faced the same conditions and problems as Taylor had, but Dripps, because of having been at the University of Pennsylvania for several years, and by working also with the Pharmacology Department, ultimately found more support. Consequently, Dripps may have had a greater ability to negotiate the necessary agreements with the hospital's Board of Managers.

* Letter from Austin Lamont to Ralph Waters, February 9, 1946. The Collected papers of Ralph Waters, M.D., Steenbock Library Collection, University of Wisconsin, Madison, Wisconsin.

† Letter from Austin Lamont to Ralph Waters, April 20, 1946. The Collected Papers of Ralph Waters, M.D., Steenbock Library Collection, University of Wisconsin, Madison, Wisconsin.

‡ Letters between Ralph Waters and Robert Dripps. The Collected Papers of Ralph Waters, M.D., Steenbock Library Collection, University of Wisconsin, Madison, Wisconsin.