add little to the cost-effectiveness arguments, physicians need to bear them in mind.

The references that Haimowitz and Goldfinger consider the "many publications that strongly refute such concerns" deserve comment. The controlled study that they cite from their own laboratory reported a total of 34 patients, 18 candidates for heart transplantation and 16 candidates for lung transplantation. Unfortunately, the study is small (Spiess et al studied 123 patients) and suffers from a lack of statistical power. Each group when analyzed separately shows a trend toward an impaired response to an orthostatic challenge ($P=.062$, $P=.052$) compared with controls. The lack of a statistical difference does little to reassure me that high-risk patients are in no more danger than are normal donors for relatively uncommon adverse events—and we are comparing risk-benefit with the current low risk of allogeneic transfusion. The case is not strengthened by the report of Kasper et al, which describes anecdotally that patients with cardiovascular disease tend to die of cardiovascular causes, whether or not they donate autologous blood.

I certainly agree that, for normal donors and for many patients, phlebotomy of a unit of blood is an extremely safe procedure, and I advocate autologous transfusion in the appropriate setting. My point is that no procedure is risk free. Now that the recognized risks of allogeneic transfusion are exceedingly small, we need to consider in the risk-benefit analysis the small but finite risks of bleeding the more vulnerable patient. Both the available literature and common sense counsel us to exercise caution and continued prudent selection.

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CORRECTION

Incorrect Table: In the article by Hensrud entitled “Clinical Preventive Medicine in Primary Care: Background and Practice. 3. Delivering Preventive Screening Services,” published in the April 2000 issue of Mayo Clinic Proceedings (Mayo Clin Proc. 2000;75:381-385), an error occurred in Table 2. The entry for “Testicle” in the column labeled “US Preventive Services Task Force” should be a dagger symbol (“†Insufficient evidence to recommend for or against screening.”), not “NR.”