Nordion clarifies agreement with JSC Isotope of Russia

In response to the *CMAJ* news article, "Uncertainties shroud medical isotope supply,"[1] we at Nordion would like to clarify the record with regard to the statement: Isotope supplier MDS Nordion has begun importing isotopes from Russia as part of broader, "multi-source" approach to isotope supply.

To state that Nordion is importing isotopes from Russia that would be available to the market is misleading. Nordion has not begun importing commercial quantities of isotopes from Russia, though it has received some samples for testing.

Nordion has an agreement with JSC Isotope of Russia, which continues to develop its processing capability and capacity of Mo-99. JSC Isotope has not fully ramped up supply, which we expect to occur before 2016. We estimate that JSC Isotope will be able to supply less than our current requirements.

In light of the quantities of Mo-99 forecasted, Nordion expects to continue to discuss with JSC Isotope our current contractual arrangements and, in addition to pursuing the completion of the MAPLE reactors through the ongoing arbitration proceedings, continue to assess potential alternate sources of long-term medical isotope supply.

These are very critical distinctions, both to Nordion and the medical community. We appreciate the opportunity to clarify.

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Reference

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Splenectomy: reducing the risk of infection

We agree with the recommendations made in the review by Petrescu and colleagues that outlines important issues surrounding vaccination and discusses the risks of overwhelming postsplenectomy infection in patients who are or will be asplenic following splenectomy.[1] Surgical or traumatic removal of the spleen is an important and easily recognizable medical event that should prompt a discussion between physician and patient regarding the risk of overwhelming postsplenectomy infection.

Equally important, but not mentioned in the review, is the hyposplenic state associated with a number of common medical conditions. In addition to congenital hyposplenism (which is rare), splenic atrophy with functional asplenia is frequently present in sickle cell disease, celiac disease, advanced HIV infection, and in patients with chronic graft-versus-host disease following hematopoietic stem cell transplantation. A complete list of medical conditions has been published elsewhere.[2]

Medically hyposplenic patients are at a similar risk of overwhelming postsplenectomy infection as those with surgical asplenism, and all such patients should be counselled about the risk and offered the appropriate vaccinations as outlined by Petrescu and colleagues.[1] Medical hyposplenism must be suspected by history of a relevant medical condition, and can be confirmed by the presence of characteristic findings on the peripheral blood smear, such as Howell–Jolly bodies, acanthocytes or nucleated red blood cells. Functional radionuclide (technetium-based) scans can provide quantification of splenic function, but are expensive and generally unnecessary. We urge clinicians to consider medically hyposplenic patients for vaccination and counselling regarding the risk of overwhelming postsplenectomy infection.

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***CMAJ* 2012. DOI:10.1503/cmaj.112-2082**

The authors respond

We thank Wuerz and Seftel for their comment.[1] Our review[2] did not address patients with functional asplenia, as it was designed specifically as a counselling scenario around the case of a patient contemplating elective splenectomy.

In our experience, the period before surgical splenectomy is often a missed opportunity for patient education and health promotion. We agree, however, that the management principles for surgically asplenic patients apply equally to patients with functional asplenia.[3] Early recognition of these patients, as outlined by Wuerz and Seftel,[1] is crucial to ensure that patients receive appropriate counselling, education about high-risk circumstances, immunizations and appropriate empiric antimicrobial therapy if they present with febrile illness, including overwhelming postsplenectomy infection.

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2. Petrescu D, Gold WL, Leis JA. Reducing the risk of infection in a patient who will undergo splenectomy. *CMAJ* 2012;184:1053-4.
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The *CMAJ* article by Petrescu and colleagues[1] emphasized the critical interventions — particularly vaccination — that can prevent life-threatening disease in an immunocompromised population. The authors note that vaccination against

the polysaccharide encapsulated bacteria *Neisseria meningitidis* (*meningococcus*), *Hemophilus influenzae*, and *Streptococcus pneumoniae* (*pneumococcus*) is recommended by the Canadian National Advisory Committee on Immunization (NACI), as published in the 2006 Canadian Immunization Guide.[2] Since 2006, recommendations incorporating newer protein conjugate vaccines for *N. meningitidis* have been made.

Polysaccharide vaccines are poorly immunogenic, even in immunocompetent people. The development of vaccines in which a polysaccharide antigen is conjugated to a protein carrier has resulted in highly immunogenic vaccines against the polysaccharide bacteria *S. pneumoniae*, *H. influenzae* and *N. meningitidis* that are now routinely used in childhood vaccination programs. In May 2007, NACI recommended the use of conjugate meningococcal vaccine for serogroups A, C, Y and W135 for immunization of people aged 2 to 55 with anatomic or functional asplenia, and that this vaccine be considered for asplenic persons 56 years of age or older.[3] Menactra (Sanofi Pasteur) and Menveo (Novartis) are 2 quadrivalent meningococcal vaccine products now available in Canada. Unlike the quadrivalent polysaccharide vaccine, regular boosters are not required following conjugate meningococcal vaccine, though some experts recommend a single booster dose 5 years after the initial dose.

In January 2012, Prevnar 13 (PNEU-C-13) (Pfizer), a 13-valent protein conjugate vaccine for *pneumococcus,* was approved by Health Canada for use in people older than 50 years of age.[4] Although no routine Canadian recommendations for offering this vaccine to asplenic adults are available, some experts recommend that clinicians consider using a protein-conjugated pneumococcal vaccine as the initial dose, followed by the polysaccharide vaccine, as this may theoretically improve antibody response and immunologic memory.[2,5] In June 2012, the United States Advisory Committee on Immunization Practices voted to recommend Prevnar 13 for use in people aged 19 years or older with functional or anatomic asplenia.[6]

Physicians should also ensure that adult asplenic persons are offered all routine adult vaccines. An adult schedule may be found at the Public Health Agency of Canada website at www.phac-aspc.gc.ca/im/is-cv/index-eng.php. Vaccine schedules for asplenic children are more complex; one can refer to the Canadian Immunization Guide[2] at www.phac-aspc.gc.ca/publicat/ccdr-mtcl/10vol36/acs-12/index-eng.php and NACI updates at www.phac-aspc.gc.ca/publicat/ccdr-rmtc/09vol35/acs-dcc-3/index-eng.php

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***CMAJ* 2012. DOI:10.1503/cmaj.112-2085**

Clarifying the assistance provided by the CMPA

We at the Canadian Medical Protective Association (CMPA) read with interest the *CMAJ* article, "Touch the screen now to see a doctor."[1] We are concerned about a statement in the article regarding the CMPA, attributed to Dr. Thom Tyson, founder and CEO of the Appletree Medical Group. He states, "Many physicians are unaware that the Canadian Medical Protective Association doesn't provide protection from privacy complaints." Physicians might misinterpret this statement. Is it intended to suggest that the CMPA does not protect physicians from privacy complaints, does not assist in responding to privacy complaints brought against members, or does not assist with paying costs and/or damages related to privacy complaints?

Irrespective of the intent of Dr. Tyson's statement, we believe clarifying the nature of CMPA's assistance to members in relation to privacy matters is important.

Members of the CMPA will typically be eligible for assistance with privacy matters arising from their practice, including complaints, investigations and associated medicolegal issues. The CMPA will assist during an investigation and proceedings, as well as with the payment of most damages awarded to patients; the CMPA may not pay fines or costs. Although the CMPA will provide advice, we will not assist members to become compliant with privacy legislation. Members with questions about privacy matters or their eligibility for assistance with such issues are encouraged to contact the CMPA. Resources are available at www.cmpa-acpm.ca to assist physicians in understanding their confidentiality and privacy obligations.

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Reference

1. Fallis J. Touch the screen now to see a doctor. *CMAJ* 2012;184:E339-40.

***CMAJ* 2012. DOI:10.1503/cmaj.112-2081**

Letters to the editor

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