Reader Comments on Antithymocyte Globulin Use for Aplastic Anemia

I wanted to thank you for your comprehensive article "Management of Patients Receiving Antithymocyte Globulin for Aplastic Anemia and Myelodysplastic Syndrome" in the August issue of the *Clinical Journal of Oncology Nursing* (Vol. 8, pp. 377–382). We have been using antithymocyte globulin (ATG) at the Fred Hutchinson Cancer Research Center in Seattle, WA, for the past two decades as pretransplant conditioning for aplastic anemia (AA) and in various protocols for the treatment of graft-versus-host disease.

I also wanted to mention that when adhering to the caveats you describe, ATG can be administered safely in the outpatient setting. Hours of operation tend to be more of a limiting factor, and we are careful to schedule patients first thing in the morning. We have found reactions to be less common than other agents administered in our clinic (e.g., rituximab, paclitaxel, carboplatin), although admittedly we administer more of those agents so a direct comparison cannot be made. As you clearly point out, emergency equipment and properly trained personnel need to be immediately available, and staff education is extremely important as well.

Seth Eisenberg, RN, OCN®
Infusion Practice Coordinator
Seattle Cancer Care Alliance
Seattle, WA

The Authors Respond

We appreciate Mr. Eisenberg's thoughtful comment and would like to offer a response regarding the standards of care for patients receiving ATG in the outpatient setting. We agree that ATG is commonly used as part of the preparative regimen in allogeneic hematopoietic stem cell transplantation (HSCT) for various diseases (Simpson, 2003; Storb et al., 2001) as well as graft-versus-host disease resulting from HSCT (Bacigalupo et al., 2001; Remberger, Aschan, Barkholt, Tollemar, & Ringden, 2001). The dose and schedule for both of these indications are not standardized, however, and often is determined based on institutional protocols.

It is important to reiterate that the indication for administration of high-dose "Atgam® [Pfizer Inc., New York, NY] (40 mg/kg per day) and Thymoglobulin® [Genzyme Corporation, Cambridge, MA] (3.5 mg/kg per day) in patients with AA and myelodysplastic syndrome" is outside the setting of HSCT. Although institutional protocols guide the delivery of any complex therapy, we would like to advocate for interdisciplinary collaboration and thorough discussion prior to the administration of ATG in any care setting. This decision making should be conducted in the context of the potential infusional toxicities based on patients' risk evaluation and their overall care needs. Additionally, staff competency and institution support, such as availability of a physician or nurse practitioner, and emergency medications and supplies must factor in the decision. Moreover, the recommendations in our article can be used to guide the provision of care to patients receiving ATG for any indication, and we advocate thoughtful interdisciplinary planning prior to its administration.

Margaret F. Bevans, RN, MS, AOCN®
Clinical Nurse Specialist
Clinical Center
National Institutes of Health
Bethesda, MD

Reem A. Shalabi, PharmD, BCOP
Clinical Pharmacy Specialist
Blood and Marrow Transplantation
National Institutes of Health
Bethesda, MD

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Letters should be mailed to Joyce P. Griffin-Sobel, RN, PhD, AOCN®, APRN-BC, Hunter-Bellevue School of Nursing, 749 West End Avenue, Apt. 9B, New York, NY, 10025 or e-mailed to CJONeditor@jsobel.com.

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