What is already known on this topic

Severe acute respiratory syndrome (SARS) is an emerging infection that is spreading worldwide

The haematological features of this disease have not been described in detail elsewhere

Previous studies have indicated that patients with SARS may develop lymphopenia and thrombocytopenia, but the significance of these findings is uncertain

What this study adds

Lymphopenia was common among patients with SARS. It was also found in various lymphoid tissues on postmortem examination and may be a marker of disease activity

Both CD4 and CD8 counts decreased during the early course of SARS. Low CD4 and CD8 lymphocyte counts at presentation were associated with adverse outcomes

Leucocytosis with neutrophilia, thrombocytopenia, and isolated prolonged activated partial thromboplastin time were common in patients with SARS

inclusion bodies, vacuoles, degenerating nuclei, or showing naked nuclei may be seen in infected marrow.[14] In most patients we found no evidence of disseminated intravascular coagulation. The postmortem findings of active bone marrow with normal megakaryoctes in patients with thrombocytopenia favour an immune cause of thrombocytopenia.

A major side effect of ribavirin is reversible haemolytic anaemia.[15 16] About 60% of our patients who received ribavirin experienced a drop of haemoglobin of more than 20 g/l. Despite this high drop, ribavirin was well tolerated and none of the patients needed withdrawal of treatment or transfusion. The development of anaemia may be a cause for concern. None the less haemolysis was transient, and haemoglobin counts improved after treatment with ribavirin had been completed in all cases. Careful monitoring of haemoglobin is advisable for patients who receive ribavirin.

Conclusions

Lymphopenia, in particular T lymphopenia, was common among patients with SARS in our study. A notable drop in CD4 and CD8 lymphocyte counts occurred early in the course of the syndrome and was associated with adverse outcomes. Thrombocytopenia, neutrophilia, and transient prolonged activated partial thromboplastin time were other common findings. Further studies to evaluate the mechanisms of these manifestations may help us to understand this disease.

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Corrections and clarifications

Risk of subsequent thromboembolism for patients with pre-eclampsia

Sometimes an error persists beyond the *BMJ* and is noticed not by a reader or author but by one of our sister journals preparing the article for publication—in this case *BMJ USA*. In this Research Pointer by Carl van Walraven and colleagues (12 April, pp 791-2) we allowed a wrong confidence interval to slip through. In the last sentence in the first paragraph of the Methods section, the 95% confidence interval for the specificity (67%) of the ICD-9 codes should be 59% to 74% [not 79% to 94%].

ABC of antithrombotic therapy: Venous thromboembolism: treatment strategies

One of our eagle eyed readers alerted us to a surplus of zeros in this article by Alexander G G Turpie and colleagues (*BMJ* 2002;325:948-50). In the third sentence in the final paragraph on unfractionated heparin, the authors should have written the platelet count as $100x10^9$/l [not $100\,000x10^9$/l].