

\$8,000 that Ryan proposes, but the subsidy is only for people who will be 65 years of age in 2022 — the only seniors affected in 2022. Everyone who is older would be grandfathered into the current program. For the 65-year-olds, the \$8,000 is a far greater share of the total than it would be for the average beneficiary, and the subsidy will increase as people age. Although most data reported are not granular enough to indicate what Medicare or total spending will be for persons 65 to 66 years of age, published Medicare numbers make this point: average Medicare spending per person for those people between 65 and 74 years of age in 2006 was \$6,497; for those 75 to 84 years of age it was \$10,297, and for those over 85 years of age it was \$12,408.¹

Manthous suggests increasing the age of eligibility for Medicare to 67 years as a way to generate substantial savings for the program. I support his suggestion and would prefer to see consideration of a gradual increase to 70 years of age for similar reasons, although it would be important to provide access to full benefits at 65 years of age for people who are unable to work for reasons of disability. People over the age of 65 years who cannot find a job or who do not have employer-sponsored insurance could presumably gain coverage through the health insurance exchanges. Manthous has probably overestimated the savings, however, since the average spending for persons in the 65-to-74-year-old class that he used for his estimate is greater than the average Medicare expenditure for 65- and 66-year-olds.

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Since publication of her article, the author reports no further potential conflict of interest.

1. Data book: healthcare spending and the Medicare program.

Washington, DC: MedPac, June 2010:22. (<http://www.medpac.gov/documents/Jun10DataBookEntireReport.pdf>.)

MR. JOST REPLIES: In my article I suggested that both the Ryan “Roadmap” and the ACA save Medicare money by shifting costs — to beneficiaries and to providers, respectively. Manthous proposes that Medicare instead be saved by shifting costs to persons 65 and 66 years of age (and to their employers). Increasing the eligibility age presents several problems. First, this is the healthiest group of Medicare beneficiaries. How much money will actually be saved as a result of their exclusion?¹ Second, how much of the cost of insuring this group would still be paid by the federal government through Medicaid, or after 2014, through the premium tax credits? Third, will this group be able to find affordable health insurance in the private market?² Under the ACA, they can be charged rates three times as high as those charged to younger people, but current insurance provisions would probably cost even more and may not be available at all to those with preexisting conditions. Fourth, do we really want to force this group to stay in the workforce, given how many younger people cannot find employment? There are no easy solutions to reducing Medicare costs.

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Since publication of his article, the author reports no further potential conflict of interest.

1. Waidman TA. Potential effects of raising Medicare's eligibility age. *Health Aff (Millwood)* 1998;17:156-64.
2. Newman T, Cubanski J. Raising the age of Medicare eligibility: a fresh look following implementation of health reform. Menlo Park, CA: Kaiser Family Foundation, 2011. (<http://www.kff.org/medicare/upload/8169.pdf>.)

Anaphylaxis from Peanuts Ingested by Blood Donors?

TO THE EDITOR: Jacobs et al. (May 19 issue)¹ suggest that transfusion-related anaphylaxis occurred after passive transfer of peanut allergen to a sensitized person. There are at least two major problems with this conclusion. First, allergic transfusion reactions are relatively common and can be severe when platelets or other serum-rich products are used.² Second, the transfused material was extensively analyzed, but there is no evidence

that the platelets actually contained any allergen, even though a new enzyme-linked immunosorbent assay for the detection of peanut peptide is available. This assay was developed by one of the authors³ and cited in the letter. Using monoclonal antibodies and high-performance liquid chromatography, we and others have tried unsuccessfully to detect any circulating peanut protein in volunteers after very large ingestions (unpublished

data). We therefore regard with skepticism the assumption that physiologically relevant contamination occurred, when only three of five donors consumed several handfuls of peanuts the night before donation.

Given that food allergy affects 4 to 6% of children in the United States, it is critical that the potential public health risk of allergen-contaminated blood products be clarified with rigorous study and not an unsubstantiated and speculative report.

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1. Jacobs JFM, Baumert JL, Brons PP, Joosten I, Koppelman SJ, van Pampus ECM. Anaphylaxis from passive transfer of peanut allergen in a blood product. *N Engl J Med* 2011;364:1981-2.
2. Domen RE, Hoeltge GA. Allergic transfusion reactions: an evaluation of 273 consecutive reactions. *Arch Pathol Lab Med* 2003;127:316-20.
3. Baumert JL, Bush RK, Levy MB, et al. Distribution of intact peanut protein and digestion-resistant Ara h 2 peptide in human serum and saliva. *J Allergy Clin Immunol* 2010;123:Suppl:S268. abstract.

THE AUTHORS REPLY: Severe anaphylactic reactions to blood transfusions are rare, elusive, and unpredictable.¹ Even though less than 10% of the

reactions are related to anti-IgA antibodies, this remains the best-documented cause, and most guidelines and physicians focus on testing for it. Our letter was intended to raise awareness among clinicians that an as-yet unexplored mechanism can be considered when no obvious cause of the allergic reaction has presented itself.

We agree with Vickery et al. that our data do not prove causality, but our findings highlight the need to consider donor-ingested peanut allergens as a cause of anaphylactic transfusion reactions in sensitized recipients. Further research is required, not only on the presence of peanut-derived peptides in transfusion products from donors who have consumed peanuts, but also on the minimal levels of such peptides required for an allergic reaction to occur, since to our knowledge no data on these issues are published.

As a major cause of severe noninfectious adverse events associated with transfusion, anaphylactic reactions are largely uncharted territory, and indeed they call for concerted study, as Vickery et al. emphasize.

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Since publication of their letter, the authors report no further potential conflict of interest.

1. Domen RE, Hoeltge GA. Allergic transfusion reactions: an evaluation of 273 consecutive reactions. *Arch Pathol Lab Med* 2003;127:316-20.

Kidney Paired Donation — The Next Step

TO THE EDITOR: There is a worldwide shortage of kidneys for renal transplantation. In the United States, the number of patients on the deceased-donor waiting list now exceeds 88,000. However, additional donations of living-donor kidneys can be facilitated by means of a strategy of simple communication and coordination known as kidney paired donation (KPD). In its simplest form, this system makes it possible for two donors who are not compatible with their intended recipients to swap kidneys, allowing compatible transplants. As a further elaboration of this strategy, donor-recipient pairs may also participate in chains of transplants, triggered by an altruistic donor and often terminating with a donation to the waiting list. Optimized algorithms can evaluate all pos-

sible permutations of matches within a registry by the use of criteria based on chain length, degree of HLA match, estimated cold-ischemia time, equity (i.e., a fair opportunity for everyone with end-stage renal disease), and patient preferences.¹ Nationwide exchange registries have already facilitated hundreds of transplantations in the United States, and the United Network for Organ Sharing (UNOS), the governing body for organ allocation in the United States, has developed a pilot program with the eventual goal of consolidating KPD across all 248 U.S. kidney-transplant programs. More and higher-quality matches can be found within larger registries, especially for highly sensitized patients.²

A natural next step is to develop international