

CORRESPONDENCE

Clinical immunology

To the Editor:

The article by Dr. Vaughan (J. ALLERGY CLIN. IMMUNOL. 50: 294, 1972) is of special interest at this time because of the rapid advances made in clinical immunopathology and because of the pending board certification in clinical immunology and allergy.

We shall, therefore, address ourselves primarily to Dr. Vaughan's first question, "What is clinical immunology?" We heartily agree with the concept expressed in this editorial and hope to clarify some minor modifications of this concept as we see them in the following communication.

The emerging concept of immunology may be interpreted as approaching clinical immunology from two separate aspects. One of these, clinical immunopathology, provides for the laboratory testing of patients in the areas of serology, immunofluorescence, immunochemistry, tissue typing, and cellular immunity. This aspect of clinical immunology falls in the realm of pathology, and can be subclassified as clinical immunopathology.

The second aspect, involving the clinician who may "cut across subspecialties of clinical practice," may be interpreted in two ways. Does it really mean that the clinician who qualifies as a clinical immunologist must be thoroughly conversant with the immunopathogenetic mechanisms involved in all of the various disease categories listed in Fig. 1 and must also be competent to manage (diagnosis and treatment) all of these conditions?

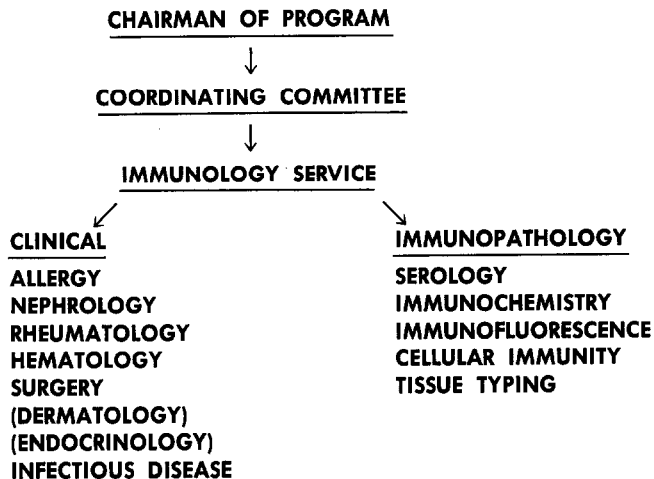


FIG. 1.

It is perfectly obvious that no clinician can assume such competence. This is not to say that the clinical immunologist-allergist should not be thoroughly familiar with all of the various immunologic phases of diseases of hypersensitivity. He should, however, be primarily and thoroughly familiar with immunopathogenetic mechanisms, laboratory procedures, and clinical aspects involved in anaphylaxis, atopy, delayed hypersensitivity (allergic eczematous contact dermatitis), etc. He must of necessity have only a broad knowledge or an interest in immunologic principles involved in rheumatology, immunohematology, transplantation immunity, nephrology, etc.

In line with this thinking, a clinical immunology program has been established at the

University Health Center of Pittsburgh which is presented as one possible means of coordinating the two types of clinical immunology (patient care and laboratory) identified by Dr. Vaughan.

A clinical immunopathology laboratory provides testing in the areas previously outlined, establishes new tests as needed by each of the clinical services, provides research training facilities, and provides consultation for the interpretation of laboratory tests. Each clinical service is responsible for determining its needs in the area of immunology and how it wishes to fill them. One possibility is for clinically trained fellows (hematology, nephrology, rheumatology, allergy, etc.) to specialize in immunologic diseases in their area of competency. They would then assume responsibility for diagnosis, treatment, and continuing care of the patients within their own specialty. An individual who would cut across the various specialties would be one whose interests lie in immunosuppressive therapy, analogous to a specialist in infectious disease.

A clinical immunology coordinating committee serves to maintain effective communication among the various services, to provide a focus for teaching, to assist in collaborative research, and to provide a forum for the interchange of ideas. All medical subspecialties are represented on the coordinating committee which selects a chairman to direct the entire program. Through this means each medical service maintains contact with the patients whom they can most effectively manage, and each is provided with the full capability of a laboratory that specializes in the immunologic aspects of disease.

This view of clinical immunology avoids the difficulty raised by Dr. Vaughan whereby a clinical immunology subspecialty would impinge upon the established areas in medicine. We hope that the organizational structure of clinical immunology will be rapidly settled, so that training programs can be established to fill the needs of this embryonic discipline.

*Bruce S. Rabin, M.D., Ph.D., Assistant Professor of Pathology;
Associate Director, Clinical Immunopathology
University Health Center of Pittsburgh, Pittsburgh, Pa.
Leo H. Criepp, M.D., Clinical Immunology and Allergy
Veterans Administration Hospital, Pittsburgh, Pa.*

Reply

I am very much indebted to Drs. Rabin and Criepp for their reaction to my comments on "The Emerging Concept of Clinical Immunology" (*J. ALLERGY CLIN. IMMUNOL.* 50: 294, 1972). They have rightly identified a very difficult problem for the emerging concept. The problem is organizational, but at the same time they have offered a solution. Their Fig. 1 proposes what has already appeared in some medical schools: an Immunology Committee, or as they call it, a Coordinating Committee. The purposes of such a Committee would be twofold. One is to provide exchange of information, cross-fertilization, and mutual aids in service among the various participating groups or individuals. The other would be to provide an unusual and exciting breadth of experience to trainees and fellows being admitted to the program.

We are developing early experience with this type of program at Scripps Clinic and Research Foundation, expecting that those in training will, after a broad initial experience, gravitate to that particular subsection in clinical immunology in which he wishes to concentrate himself. We believe that the experience will make better allergists, better rheumatologists, better hematologists, etc., out of those who end up concentrating all of their attention in those particular areas, and, in addition, will create a few who can only be called clinical immunologists.

My thanks again go to Drs. Rabin and Criepp for bringing out these additional facets.

*John H. Vaughan, M.D., Chairman of the Clinical Divisions
Scripps Clinic and Research Foundation*