cartridge or as a result of jostling of the device after the rinse has been performed.

There have been previous studies regarding plasma perfusion; however, those studies were conducted years ago when the plasma separation technology was relatively inconvenient to use. In addition, none of those studies employed a protein-compatible adsorbent; consequently, maximum adsorptive capability could not be achieved. These factors rendered plasma perfusion irrelevant as a possible therapeutic option, and hemoperfusion has remained the preferred modality. Based on your initial, well-received results, as well as the fact that plasma separation technology is now much more widely available, it is our belief that your work may establish plasma perfusion as a treatment option for some types of patients and for some types of intoxications.

I have enclosed some selected references which should be of interest to you. The topics covered by these publications include membrane and coating blood compatibility (this information is also applicable to plasma perfusion), particulate generation, plasma perfusion and plasma replacement, and drug removal.

You may find some of the adsorbent coating papers to be confusing; in some cases, authors mute their findings in deference to other researchers. If you read enough of the scientific literature, you will be able to uncover authors contradicting themselves from paper to paper. The information contained in the flyer entitled "Clark - The World's Leading Hemoperfusion" should serve as an instructive summary regarding coating technology considerations.

You will also note, especially in the early research, that a lot of attention is paid to platelet loss as well as particulate release; however, you should also notice that these issues are almost never discussed from a clinical viewpoint. Platelet loss is frequently reported in percentages, but, as we discussed when we met, the patient's clinical condition is at least as significant a factor affecting platelet loss as is coating blood compatibility. Patients suffering from hepatic failure should always be expected to exhibit platelet loss owing to the activation of their platelet surface mechanisms by the disease process itself, and the extracorporeal removal of such platelets is likely beneficial in that these platelets would otherwise contribute to D.I.C. Similarly, different drugs affect platelet activation differently; consequently, expression of platelet removal simply in terms of a percentage is scientifically invalid and clinically irrelevant. The extent of platelet loss is not easily predictable in any given patient's case, but no patient treated with the Clark cartridge has ever needed a platelet transfusion as a result of platelet during treatment with the