First premarital screening of thalassaemia carriers in intermediate schools in Latium

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SUMMARY In the 1975 to 1976 school year, under the auspices of the Health Authorities of the Latium Region, the Rome Microcythaemia Centre carried out for the first time a partial screening survey of thalassaemia carriers among the students of the compulsory intermediate school in Latium. This work was the beginning of a new preventive school health service aimed at the prophylaxis of Cooley’s disease.

In 23 places investigated in Latium, 17,724 students were examined, 13,354 of whom were in Rome and 4,370 elsewhere. The mean percentage of co-operation was 70% and the mean percentage of thalassaemia 2.42%.

Thalassaemic students were invited to attend the centre for a check-up along with their families, about half had already come in by the end of June 1976. All students examined, whether normal or thalassaemic, have received written results of the tests.

The screening survey aroused notable interest and obtained wide approval both at school and at home. The news of being thalassaemia carriers, even if not welcome, was never the cause of family tragedy.

Under the auspices of and with financial support from the Health Authorities of the Latium Region, the Rome Microcythaemia Centre initiated and carried out partial screening for thalassaemia carriers in third-year intermediate students in the school year 1975 to 1976. The centre intends this first screening to be the start of a new preventive school health service to be carried out every year in Latium on all third-year students of the compulsory school. The ultimate aim of this project is the prophylaxis of Cooley’s anaemia. The detection of thalassaemia is in fact the indispensable premise for any form of pre- or postmarital prophylaxis of Cooley’s anaemia.

Screening stages

First of all, students and teachers of the intermediate schools were informed, class by class, with a brief and simple lecture, of the existence and the dangers of thalassaemia. At the end of the explanatory talk the students received an informative letter for their parents, requesting their permission to carry out the tests, to be brought back to school as soon as possible, duly signed by father or mother.

Informed consent having been obtained, a team of doctors took 1 ml venous blood from each student in the school dispensary. The samples were transferred that same morning to the centre’s laboratory.

All tests were done in each school within about 10 days, and the results were delivered by the centre to the school doctors. A card bearing the result was sent to each non-thalassaemic student, while the thalassaemic or suspected thalassaemic students were sent a letter which, apart from communicating the result as ‘suspected thalassaemia’, invited the student to come to the centre with the rest of his family for another examination.

The main aim of this second call-up was that of confirming, before definite communication of the results, the effective presence of thalassaemia in the subjects selected by the first screening. This was necessary both to exclude the possibility of mistakes in labelling of samples and to identify the cases of atheropenic anaemia—a disease which, as is known,
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resembles the entire haematological picture of thalassaemia.

Next the idea was to inform the families of their condition and of the need to have information about the marital choices of the thalassaemic offspring; at the same time it was hoped to hear their opinion of the undertaking carried out in the school and their reaction on learning the results. Finally, it was considered advisable to examine immediately the other offspring of these families.

The letters for the positives were delivered elsewhere by the school doctor to those concerned or, better, to their parents, while the negative results were handed out, a few at a time, in class. Thus, recognition of the positives by their classmates was avoided and at the same time the presence of a doctor when the results of the tests were communicated to avoid unnecessary alarm in students and parents.

At the end of the tests the families coming to the check-up received the results from the doctors at the centre. They were first of all informed of the type of thalassaemia they were carrying and, for α-thalassaemia, it was explained that this would not damage offspring in the case of marriage to a β-thalassaemia carrier, but only in the case of marriage to another α-thalassaemia carrier. The results were then issued to all subjects examined, the normals receiving the usual card; the thalassaemics received another type of card which illustrates the danger of mating between two β-thalassaemics and the necessity that thalassaemia carriers should have their future partners examined as soon as possible.

Subjects and methods

Work was begun in Rome and carried out on a vast group of intermediate schools in November 1975. Subsequently another 6 towns in the province of Rome (Fig. and Table 1) were investigated. In the province of Viterbo, thanks to the active collaboration of local authorities, it was possible to investigate 9 towns; in the two provinces south of Rome (Frosinone and Latina) 5 of the main towns were examined (Fig. and Table 1).

The screening was carried out in two stages. In the first stage, for all the samples taken daily (from 200 to 400), osmotic fragility was studied with the technique standardised by Silvestroni and Bianco (1945), and red cell morphology was examined on an unstained slide.

A first discrimination was made with these two blood tests, that is the samples which showed an increased cell fragility and altered morphology of red cells, or either of these two characteristics, and which, therefore, had the greatest likelihood of being thalassaemic, were selected. The experience of Silvestroni and Bianco (1973), in 30 years’ work on thalassaemias in Italy, demonstrates this (Table 2): in fact, 88% of carriers of the various different varieties of thalassaemia have both the above characteristics, 10% only one, and 2% neither one nor the other.

With the simultaneous use of the two above tests 98% of thalassaemia carriers were, therefore, already selected in the first stage of screening; this is the first group of subjects sent to the second stage of screening.

Fig. Cities and towns investigated in the provinces of Latium. Percentage frequencies of thalassaemia in third-year intermediate students.
Table 1. Results of screening for thalassaemia among 3rd-year intermediate students in provinces of Rome, Viterbo, Latina, Frosinone

<table>
<thead>
<tr>
<th>Place</th>
<th>No enrolled</th>
<th>No. tested</th>
<th>% tested</th>
<th>Thalassaemic carriers</th>
<th>Percentage thalassaemia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Province of Rome</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rome</td>
<td>18 551</td>
<td>13 354</td>
<td>72</td>
<td>312</td>
<td>2.33</td>
</tr>
<tr>
<td>Velletri</td>
<td>525</td>
<td>340</td>
<td>64</td>
<td>8</td>
<td>2.35</td>
</tr>
<tr>
<td>Colleferro</td>
<td>324</td>
<td>185</td>
<td>57</td>
<td>2</td>
<td>1.08</td>
</tr>
<tr>
<td>Civitavecchia</td>
<td>515</td>
<td>292</td>
<td>56</td>
<td>6</td>
<td>2.05</td>
</tr>
<tr>
<td>Artena</td>
<td>160</td>
<td>159</td>
<td>99</td>
<td>2</td>
<td>1.25</td>
</tr>
<tr>
<td>Valmontone</td>
<td>167</td>
<td>113</td>
<td>67</td>
<td>2</td>
<td>1.76</td>
</tr>
<tr>
<td>Segni</td>
<td>118</td>
<td>93</td>
<td>78</td>
<td>3</td>
<td>3.22</td>
</tr>
<tr>
<td>20 360</td>
<td>14 536</td>
<td>71</td>
<td>335</td>
<td>2.30</td>
<td></td>
</tr>
<tr>
<td>Province of Viterbo</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Viterbo</td>
<td>782</td>
<td>735</td>
<td>93</td>
<td>18</td>
<td>2.44</td>
</tr>
<tr>
<td>Bagnaia and Vitorchiano</td>
<td>62</td>
<td>56</td>
<td>90</td>
<td>2</td>
<td>3.57</td>
</tr>
<tr>
<td>Celano, Graffignano, Grotte S. Stef.</td>
<td>87</td>
<td>74</td>
<td>85</td>
<td>2</td>
<td>2.70</td>
</tr>
<tr>
<td>Canepina</td>
<td>50</td>
<td>44</td>
<td>88</td>
<td>3</td>
<td>6.81</td>
</tr>
<tr>
<td>Canino and Cellere</td>
<td>80</td>
<td>67</td>
<td>83</td>
<td>4</td>
<td>5.97</td>
</tr>
<tr>
<td>Tarquinia</td>
<td>144</td>
<td>83</td>
<td>57</td>
<td>1</td>
<td>1.20</td>
</tr>
<tr>
<td>1 205</td>
<td>1 059</td>
<td>87</td>
<td>30</td>
<td>2.83</td>
<td></td>
</tr>
<tr>
<td>Province of Latina</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fondi</td>
<td>424</td>
<td>290</td>
<td>68</td>
<td>13</td>
<td>4.48</td>
</tr>
<tr>
<td>Formia</td>
<td>470</td>
<td>332</td>
<td>70</td>
<td>10</td>
<td>3.01</td>
</tr>
<tr>
<td>Gaeta</td>
<td>388</td>
<td>245</td>
<td>63</td>
<td>6</td>
<td>2.44</td>
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<tr>
<td>1 282</td>
<td>867</td>
<td>67</td>
<td>29</td>
<td>3.44</td>
<td></td>
</tr>
<tr>
<td>Province of Frosinone</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frosinone</td>
<td>624</td>
<td>451</td>
<td>72</td>
<td>13</td>
<td>2.88</td>
</tr>
<tr>
<td>Pontecorvo</td>
<td>404</td>
<td>226</td>
<td>56</td>
<td>9</td>
<td>3.98</td>
</tr>
<tr>
<td>Cassino</td>
<td>1 133</td>
<td>585</td>
<td>52</td>
<td>13</td>
<td>2.22</td>
</tr>
<tr>
<td>2 161</td>
<td>1 262</td>
<td>58</td>
<td>35</td>
<td>2.77</td>
<td></td>
</tr>
<tr>
<td>General total =</td>
<td>25 009</td>
<td>17 724</td>
<td>70</td>
<td>429</td>
<td>2.42</td>
</tr>
</tbody>
</table>

With the 2% residue containing α-thalassaemia carriers (which cannot be detected by any haematological or electrophoretic investigation when we are dealing with latent α-thalassaemia) and carriers of isolated increase of HbA₂ (which can be identified only by way of the electrophoretic examination of Hb), we attempted to select at least some of these latter subjects by sending to the second stage of screening all those cases with even minimum alterations of the red cell morphology. On the average, 5 to 6% of the daily samples were taken and on the whole about 900 subjects (second group). Finally, with the aim of further checking the screening method adopted, over the course of the whole survey 1000 subjects who had turned out to be completely normal in the two preliminary blood tests were chosen at random and subjected to the second stage of screening (third group).

In the second stage of screening all the samples from the first and second group underwent, on the same day as sampling, more complete blood tests (Hb measurement, red cell count in 0-9 and 0-36% saline; red cell morphology in counting chamber, haematocrit). The next day the same samples were submitted to electrophoretic examination of haemoglobin which, besides giving diagnostic confirmation, also typed the thalassaemia.

The blood tests were done using conventional methods: the Hb was given in g/dl by the Drabkin method, the red cell count was done with the optical

Table 2. Detection of thalassaemia through testing of red cell fragility and morphology

<table>
<thead>
<tr>
<th>Osmotic fragility</th>
<th>Alterations of red cell morphology</th>
<th>Type of thalassaemia</th>
<th>Percentage of all thalassaemias</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decreased</td>
<td>Present</td>
<td>β-thalassaemia</td>
<td><strong>88</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>α-thalassaemia</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>δ-thalassaemia with high Hb F</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>δβ-thalassaemia with Hb Lepore</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Thalassaemia with Hb H</td>
<td></td>
</tr>
<tr>
<td>Decreased</td>
<td>Absent</td>
<td>β-thalassaemia</td>
<td><strong>5</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>α-thalassaemia</td>
<td></td>
</tr>
<tr>
<td>Normal</td>
<td>Present</td>
<td>β-thalassaemia</td>
<td><strong>5</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>α-thalassaemia</td>
<td></td>
</tr>
<tr>
<td>Normal</td>
<td>Absent</td>
<td>β-thalassaemia</td>
<td><strong>2</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>α-thalassaemia</td>
<td></td>
</tr>
</tbody>
</table>
microscope, and the haematocrit value was determined by the capillary method. For the osmotic fragility test the method of Silvestroni and Bianco (1945) was used; this is done in 0·36% hypotonic solution and allows the results to be obtained in only a few minutes. In fact, the blood is diluted in a red cell count pipette with a solution made up of 4 parts of Tyrode saline and 6 parts of distilled H₂O; within a very short time if the red cells have a normal osmotic fragility, the contents of the pipette become clear; if the opposite is obtained, the red cells have an increased osmotic fragility and the liquid remains opalescent.

The red cell morphology was examined, in the first stage of screening, on the unstained blood slide. For this examination it is necessary for the slide to be very thin and for the cells to be visible in a single layer and well separated from each other. In the second stage, that is in subjects fully examined from a haematological point of view, the red cell alterations were checked again in the counting chamber.

The electrophoretic study of Hb was carried out with the technique of microzone on cellogel at alkaline pH, standardised in the Rome Centre by Bianco et al., (1972) and already widely tested. The percentage of haemoglobin fractions was obtained from the stained and diaphanised strip of cellogel on a Beckman R-110 densitometer. The amount of Hb F was determined in the cases of evident increase by the 1-minute alkaline denaturation technique of Singer et al. (1951), and, in the cases of more modest increase, the HbF was assayed on a slide by the acid elution technique of Kleihauer et al. (1957).

Results

The techniques and procedures used in screening made it possible to identify among the students examined at least 98% of thalassaemia carriers and to type each case of thalassaemia. The subjects selected in the first stage on the basis of the osmotic fragility tests and red cell morphology were, with rare exceptions, all thalassaemia carriers. From the subjects in the second group (who were carriers of only very slight red cell alterations and of no other thalassaemic haematological characteristics) the electrophoretic study of Hb made it possible to identify still more cases of β thalassaemia (3 out of a total of 429 thalassaemias), rather more classifiable among the cases of isolated increase in HbA₂. In the third group (subjects negative for both haematological tests, taken at random in the course of the whole screening) out of a total of 1000 examined no case of thalassaemia was found which could be recognised by electrophoretic examination of Hb.

In the course of the whole screening 17724 third-year intermediate students were examined in various places (Fig. and Table 1).

In 94 intermediate schools in Rome, 13354 students were examined out of a possible 18551 enrolled students, that is 72%. Out of the total 13354 students examined, 312 thalassaemia carriers were identified, that is 2·33%. There is, however, a distinct difference in the various schools: in fact, frequencies were found of 0·6 to 1% and of 6·5 to 6·8%.

In the province of Rome a total of 1182 students were examined out of 1809 enrolled, that is 65%. The frequency of thalassaemia fluctuated from 1·08% to 3·22%.

In the province of Viterbo the percentage of cooperation was everywhere very high (average 87%) and altogether 1059 students were examined. The frequency was 2·44% in Viterbo, 2·83% of the whole, and in the other towns of the province it fluctuated between 1·2% and 6·8%.

In the province of Latina 3 towns were investigated and 867 students were examined of 1282 who were enrolled (67·6%). The frequency of thalassaemia fluctuated between 2·3% and 5·1%, with an overall mean of 3·34%.

In the province of Frosinone 1262 students were examined out of 2161 enrolled (58%) in the intermediate schools of Frosinone, Pontecorvo, and Cassino. The frequency of thalassaemia fluctuated between 0·5% and 4·8%, with an overall mean of 2·77%.

For all places investigated the overall mean of cooperation was 70%. In all 429 thalassaemia carriers were identified and the average frequency of thalassaemia was 2·42%. The most frequent variety in all places was β-thalassaemia, followed by α-thalassaemia and thalassaemia with Hb Lepore (Table 3). In this survey no cases were found of δβthalassaemia with normal levels of HbA₂ and raised Hb F and no cases of δβ-thalassaemia with normal levels of HbA₂ and Hb F.

Up to 30 June 1976 (that is the end of the school year) 50% of the families of thalassaemic students had already come into the centre for tests. An investigation carried out during the check-up revealed that all these families had greatly appreciated the survey carried out.

<table>
<thead>
<tr>
<th>Place</th>
<th>β-thalassaemia</th>
<th>α-thalassaemia</th>
<th>Hb Lepore</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rome</td>
<td>287</td>
<td>19</td>
<td>6</td>
</tr>
<tr>
<td>Province of Rome</td>
<td>22</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Province of Viterbo</td>
<td>30</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Province of Latina</td>
<td>28</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Province of Frosinone</td>
<td>35</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>402</td>
<td>21</td>
<td>6</td>
</tr>
</tbody>
</table>
in the schools, and all declared that they preferred to
know the condition of their children exactly than to
remain in a dangerous ignorance. In no case did the
news of being thalassaemic, even though not welcome,
disturb the serenity of the family. A telephone inquiry
to families still absent from the check-up revealed that
except for some cases of real difficulty the most
frequent cause of absence from the check-up was
ignorance or ignorance of the problem and not a
refusal to participate in the project. After the telephone
calls many of these families came to the centre for
tests.

Conclusions

The results of this first experiment of screening for
thalassaemia in the intermediate school can be
considered satisfactory on the whole. That does not
mean that it was an easy task. In the beginning,
especially, the difficulties and obstacles were consider-
able and sometimes insurmountable, and the work
throughout the whole project was difficult.

The average percentage of co-operation of 70% shows
the degree of interest that the new undertaking
(though aimed at populations to a large extent still
ignorant of the existence of the thalassaemias) aroused
in students and their families. An analysis of the single
results shows that where the job of information was
exhaustive and well done (or the population was
already conscious of the problem) consent always
reached a high level of up to 95 to 100%. To this fact
is added the high percentage of thalassaemic families
who quickly responded to the invitation to come to
the centre for a check-up of all the members, and the
observation that among the families still absent after
the first request the most frequent causes of absence
were ignorance or negligence and never refusal to take
part in the scheme; this indicates the lack, in many
families today, of a eugenic awareness and therefore
the need for a campaign for more complete infor-
mation; it does not reflect the failure or uselessness of
school screening.

On the whole these results suggest that the survey
should be repeated every year and that in a short time
it will cover the whole region of Latium and a very
high percentage of students.

It is not possible to foresee at the moment what will
be the future behaviour of today’s adolescents when
approaching marriage, faced with the choice of a
criteria of prophylaxis of Cooley’s disease. In those
cases in which the parents asked whether there were
alternative solutions to the prophylaxis of Cooley’s
disease, the possibility of prenatal diagnosis was
discussed. Parents were generally not interested in this
method, however, perhaps because the problem was
not a real one for the family. But in those cases with
thalassaemic children the parents were prepared to
propose a test for thalassaemia to the prospective
partner of their thalassaemic child. The centre’s future
programme plans to have a yearly check-up of
thalassaemic families in Latium and to keep
permanently in touch with thalassaemic families, with the
aim of continuing to help the adolescents of today over
the years up to the age of marriage.

If this programme is carried out regularly, in a few
years’ time it will be possible to know whether the
population has accepted premarriage counselling for
the prevention of Cooley’s disease or has preferred
other means of defence.

However, independently of the choices of the young
thalassaemias on the subject of prophylaxis of
Cooley’s disease, it is evident that the global screening
plan suggested and carried out by the Rome Micro-
cytthaemia Centre does a useful task in the field of
social and preventive medicine in that it identifies
and informs thalassaemics before marriage; and it
gives them freedom and responsibility for making a
choice of a partner without thalassaemia, or, after
marriage, the freedom and responsibility for con-
trolling procreation.

The present model of collaboration between a
private organisation and Government Health
Authorities can in future be modified and improved,
but has already, in its present form, given proof of
working efficiently. For this reason it has seemed
worth while to bring it to the attention of the Italian
regions and of foreign countries which are equally
interested in the problem of thalassaemia.

As far as the region of Latium is concerned, the
local authorities have decided to go ahead with annual
screening for thalassaemics in schools as a regular
school health service.

The authors wish to thank the health authorities of
the Latium Region for financial and other support;
the provincial doctors and health officers of Latium;
the School Health Service of the Municipality of Rome;
and Viterbo, and in particular the many school
doctors and health workers of the schools examined,
for valuable and constant collaboration; and the
health authorities and the School Health Service of all
other municipalities investigated.

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