Red blood cell alloimmunization in sickle cell disease: prevalence in 2010

Scott T. Miller, SUNY Downstate Medical Center
Hae-Young Kim, New England Research Institutes
Debra L. Weiner, Children’s Hospital Boston
Carrie G. Wager, New England Research Institutes
Dianne Gallagher, New England Research Institutes
Lori A. Styles, Children’s Hospital & Research Center at Oakland
Carlton Dampier, Emory University
Susan D. Roseff, Virginia Commonwealth University

Journal Title: Transfusion
Volume: Volume 53, Number 4
Publisher: Wiley | 2013-04-01, Pages 704-709
Type of Work: Article | Post-print: After Peer Review
Publisher DOI: 10.1111/j.1537-2995.2012.03796.x
Permanent URL: https://pid.emory.edu/ark:/25593/rtq0k

Final published version: http://dx.doi.org/10.1111/j.1537-2995.2012.03796.x

Copyright information:
© 2012 American Association of Blood Banks.

Accessed April 21, 2019 1:12 PM EDT
Red Blood Cell Alloimmunization in Sickle Cell Disease: Prevalence in 2010

Scott T. Miller¹,², Hae-Young Kim², Debra L. Weiner³, Carrie G. Wager², Dianne Gallagher², Lori A. Styles⁴, Carlton D. Dampier⁵, and Susan D. Roseff⁶ for the Investigators of the Sickle Cell Disease Clinical Research Network (SCDCRN)

¹State University of New York-Downstate Medical Center/Kings County Hospital Center, Brooklyn NY
²New England Research Institutes, Watertown, MA
³Children’s Hospital Boston, Boston, MA
⁴Children’s Hospital & Research Center at Oakland, Oakland CA
⁵Emory University School of Medicine and Children’s Healthcare of Atlanta, Atlanta, GA
⁶Virginia Commonwealth University Health System, Richmond, VA

Abstract

BACKGROUND—Transfusion of red blood cells is frequently required for care of individuals with sickle cell disease. Alloimmunization rates are high, and may be reduced by matching for red cell antigens that can cause alloimmunization.

STUDY DESIGN AND METHODS—During the PROACTIVE Feasibility Study, patients with sickle cell disease age two years or older admitted for pain without acute chest syndrome were enrolled for possible randomization to preventive blood transfusion or standard care. Transfusion and antibody histories were obtained at each site, and antibody screening was done, to assess transfusion burden and alloimmunization prevalence. Participating sites were surveyed regarding antigen matching practice.

RESULTS—237 patients (169 SS, 42 SC, 15 Sβ⁰-thalassemia, 11 Sβ⁺-thalassemia), 118 males and 119 females, were enrolled. Mean age was 19.3 years (range 2.0–68.0); there were 122 children and 115 adults. 75.8% had received at least a single transfusion of red blood cells prior to the study. Thirty-four patients (14.4%) had a history of at least one alloantibody and 17 of these had more than one. When surveyed, 19 sites (83% of responders) reported antigen matching to at least include C, E and K for transfusion of all patients with sickle cell disease.

CONCLUSION—Though antigen typing prior to transfusion of people with sickle cell disease and providing antigen negative units is now widely employed by sickle cell centers, the
alloimmunization rate remains quite high in contemporary sickle cell populations and may be due in large part to transfusions received at institutions not providing extended matching.

**Keywords**

Transfusion; PROACTIVE; Duffy blood group; Cooperative Study of Sickle Cell Disease

**INTRODUCTION**

Transfusion of red blood cells is used to treat and prevent complications of sickle cell disease (SCD). Alloimmunization to non-ABO red cell antigens is potentially problematic and commonly encountered, at least in part due to antigen disparity between blood donors and people with SCD. Antigen-matching beyond standard ABO and Rh typing has reduced this alloimmunization rate in single institutional trials and in a research setting. In the PROACTIVE Feasibility Study (ClinicalTrials.gov NCT00951808), eligible patients with SCD hospitalized for pain were randomized to prophylactic transfusion to pre-empt nosocomial acute chest syndrome (ACS) or to standard care. Data collected included each patient’s previously identified red cell alloantibodies. In addition, patients were screened for alloantibodies on enrollment to help assess feasibility of finding compatible red cells in a timely fashion for transfusion of randomized patients. These data inform regarding contemporary prevalence of alloimmunization in a broad group of patients with SCD cared for at 26 centers participating in the Sickle Cell Disease Clinical Research Network (SCDCRN), as compared to rates seen in participants in the Cooperative Study of Sickle Cell Disease (CSSCD) nearly three decades ago.

**MATERIALS AND METHODS**

**PROACTIVE Feasibility Study Design**

Thirty-one centers participating in the SCDCRN were encouraged to enroll patients in the PROACTIVE Feasibility Study, designed with an observation arm to determine the utility of elevated serum levels of secretory phospholipase A2 (sPLA2) in predicting ACS, and an intervention arm to evaluate the feasibility of using timely transfusion to prevent ACS in those at risk; type IIa sPLA2 is a calcium dependent protein that cleaves phospholipids to generate non-esterified fatty acids and lysosphospholipids and is a potent inflammatory mediator. Subjects who developed fever and a serum level of sPLA2 > 100 ng/mL were eligible to be randomized to transfusion or standard care alone to determine whether ACS could be prevented. Patients with SCD, genotype Hb SS, SC, or Sβ-thalassemia age 2 years or older admitted for pain who did not already have ACS were eligible for the observation arm of the trial. Exclusion criteria included: transfusion within 60 days of study entry or treatment with corticosteroids; coexisting conditions; and pregnancy or preferences/conditions (including a history of alloimmunization) that might require or preclude prompt transfusion.

**Site Survey Regarding Antigen Matching for Transfusion**

Prior to commencement of PROACTIVE, participating centers were asked whether “extended phenotyping is routinely done on SCD patients”. After termination of the study,
sites were again polled as to whether patients with SCD (or a subgroup, i.e. Hb SS or chronic transfusion patients) who need red blood cell transfusion are given red blood cells not only matched for ABO/Rh and any previously identified alloantibodies, but also matched for additional antigens. If so, a check-off list of antigens was provided to indicate which ones are included in the antigen match.

**Transfusion**

Due to the sometimes rapid progression of ACS, feasibility of prompt provision of the potentially preventive RBC transfusion was a primary objective of the study; therefore a transfusion history and blood bank records of all enrollees were required. Antibody histories and red cell phenotype data, if available, were obtained from blood banks at each site. Results of antibody screening from blood collected on enrollment and, for randomized subjects only, before and after each transfusion and at a follow-up visit on day 28 were collected.

**Statistical Analysis**

Alloimmunization prevalence was analyzed by transfusion history, site practice regarding antigen matching, age and (in adults) gender. Statistical analyses were performed at the Data Coordinating Center (New England Research Institutes, Watertown, MA) with SAS® release 9.2 (SAS Institute, Cary, NC). Descriptive statistics were reported as the number and percent, the mean and standard deviation/standard error, or the median and range. Differences in categorical variables were tested by chi-square or Fisher’s exact test and differences in continuous variables were tested by t-test.

**RESULTS**

Prior to PROACTIVE termination due to inadequate accrual of randomized subjects, 237 patients (169 SS, 42 SC, 15 Sβ₀-thalassemia, 11 Sβ⁺-thalassemia), 118 males and 119 females, were enrolled in the PROACTIVE trial from July 2009 through June 2010 by 26 centers, 2 to 27 patients (mean 9.5) per center. Alloimmunization was cited as a reason for exclusion of 27 of 378 (7.1%) subjects identified as potentially eligible for enrollment. Mean age of enrolled patients was 19.3 years (range 2.0–68.0); there were 122 children and 115 adults (age ≥18 years). More than three quarters of the participants had received at least a single transfusion of red blood cells prior to the study; more than two thirds of children under age 10 had been transfused (Table I). Forty-five percent of adults over age 35 had received 10 or more transfusions.

Blood bank data were reported on 236 subjects. Thirty-four patients (14.4%), 14 (11.5%) children and 20 (17.4%) adults (p=0.19), had a history of at least one alloantibody and 17 of these had more than one. There was no difference in alloimmunization between adult men (15.7%) and women (18.8%) (p=0.28). Alloimmunization prevalence by age and transfusion load is depicted in Table I. Among children, 9 of 56 (16.1%) with 1–5 transfusions had alloantibodies compared to 4/17 (23.5%) with >10 transfusions (p=0.48). Four of 32 (12.5%) adults with 1–5 transfusions were alloimmunized compared to 10/31 (32.3%) those with >10 transfusions (p=0.07). The alloimmunization rate of heavily transfused subjects
was no different between adults and children (p=0.74). Antibodies were reported against D (2), C (9), E (9), e (5), V (2), Kell (K) (4), Js² (1), Kpᵃ (3), Kpᵇ (2), Fyᵃ (3), Fyᵇ (2), Jkᵃ (1), Jkᵇ (2), Leᵃ (2), M (4), S (3) and other (11, including 5 autoantibodies). Looking only at those 179 patients who had received at least one transfusion, 33 (18.4%), 14 (15.4%) children and 19 (21.6%) adults (p=0.28), had a history of at least one alloantibody and 16 of these had more than one; unfortunately, one subject with no reported transfusions had a blood bank history of alloantibodies to anti-D, anti-C, anti-E, anti-e, anti-Fyᵇ and anti-Jkᵃ (likely indicating incomplete data reporting for this individual). Only 18 participants (12 adults, 6 children) had antibodies detectable on screening of blood specimens obtained at enrollment; 10.5% of adults and 5.0% of children had detectable antibodies (p=0.11).

When surveyed prior to commencement of PROACTIVE, 9 of 11 responding centers said that they performed red cell phenotyping for their patients with SCD; one center did not, and one performed red cell phenotyping only for adult patients. After the termination of the study twenty-three sites (88%) responded to the follow-up survey regarding pre-transfusion antigen typing. Nineteen centers (83% of responders) reported antigen matching beyond ABO/Rh and known antibodies for all transfusions (one for genotype Hb SS only); three did this only if one (two sites) or more (one site, for chronic transfusion patients only) antibodies were known to be present, and one center “on a case-by-case basis”. There was no difference in antibody prevalence between the four centers that did not routinely provide antigen matched blood (13.7%) and those that did (14.8%) (p=0.85); within the latter group, there was no difference between those that limited matching to C, E and K antigens (14.8%) and those that did more extensive matching (14.7%) (p=0.99). Eleven sites matched for Duffy antigens (Fyᵃ and Fyᵇ).

**DISCUSSION**

Individuals with SCD frequently require transfusion of red blood cells to treat acute complications, and chronic transfusion is recommended for primary and secondary stroke prevention; it appears use of transfusion has increased over the last several decades. In a report from the CSSCD, a large natural history study of sickle cell anemia in the 1980’s, only approximately 50% of enrolled subjects had a history of transfusion at entry, as compared to 75.8% having a history of transfusion in PROACTIVE. It may be that transfusion is more frequently utilized today than during the CSSCD due to improved safety of the blood supply, documentation by the Stroke Prevention (STOP) trials of the need for indefinitely prolonged chronic transfusion for primary stroke prevention and the perception that transfusion improves outcomes of patients with acute chest syndrome. Acute chest syndrome is a leading cause of sickle cell-related hospitalization and, whereas during the CSSCD (1979–87) 26% of subjects with ACS were therapeutically transfused, during the National ACS Study (1993–7), a similar large multi-institutional observational study, 72% of ACS patients received blood.

CSSCD data were chosen for comparison since both the CSSCD and PROACTIVE were multi-institutional trials that involved centers with large sickle cell populations and expertise in their care. However, whereas all patients under care at participating institutions were eligible for entry into the CSSCD, PROACTIVE enrollees consisted only of individuals
hospitalized for pain. SCD patients with pain are more likely to have higher hemoglobin levels \(^{22,23}\) and thus perhaps a lower risk for transfusion. Higher hemoglobin levels are also seen in patients susceptible to ACS, \(^{22,24}\) a major indication for red cell transfusion, perhaps biasing PROACTIVE in the other direction, since ACS is a common indication for transfusion and thus risk for alloimmunization. The higher frequency of a history of transfusion overall in the PROACTIVE group as compared to the CSSCD would potentially increase the risk of alloantibodies.

The rate of alloimmunization of patients with SCD is higher than that of the general population, reaching 47% in one series, \(^{25}\) perhaps largely related to antigen disparity due to differences in ethnic heritage between donors and recipients; \(^3\) in addition, blood cell antigens Rh (particularly D) and are the most alloimmunogenic. \(^3,4,26–28\) Not only does allosensitization put patients at risk for acute and delayed hemolytic transfusion reactions, sometimes severe, \(^1\) but also can make a search for compatible blood difficult and costly for blood banks and providers. Antigen-matching may reduce alloimmunization. \(^6–9,29\) As demonstrated by our survey, the vast majority of our PROACTIVE sites insist on compatibility of these antigens even for non-sensitized patients, yet antibodies to C, E and remain the most commonly identified in our population.

Has this policy helped? Despite nearly universal attempts by PROACTIVE-participating sites to reduce the alloimmunization rate in their patients by extending antigen compatibility to at least the most problematic antigens (C, E and ) and often further, the alloimmunization rate remains high (14.4%; 18.4% among those by history receiving at least one transfusion) among enrolled subjects; additionally, 7.1% of potentially eligible subjects could not be enrolled to PROACTIVE due to concern that existing alloantibodies might preclude prompt transfusion, if so randomized. Site practice regarding antigen matching did not impact on alloantibody prevalence in their PROACTIVE subjects, and there was no substantive reduction even among children, who should have most benefitted from recent recommendations for antigen matching. Unfortunately, we have no specific data from PROACTIVE sites as to when antigen matching was adopted. It is somewhat surprising that transfusion load did not appear to affect alloimmunization rates in either age group, though there was a trend toward a higher prevalence of alloantibodies in adults with more transfusion exposures as opposed to fewer.

The CSSCD documented by blood bank history and serologic screening prior to transfusion (90% concordant) that the overall alloimmunization rate upon enrollment to the study, 12.5%, was similar to that of PROACTIVE patients; \(^{11}\) the SS genotype and increasing age were associated with a higher risk of alloimmunization. It is possible that antibody histories available during the CSSCD may have been less comprehensive than available today or that the current computerized records are more accurate and yield more complete results; the true alloimmunization rate may have been higher. In addition, current methods of antibody detection are more sensitive than those used at the time of the report in 1990, raising the possibility that these data reflect better detection, not a similar alloimmunization rate.

In a survey of those selected to participate in the National Heart Lung and Blood Institute-supported Comprehensive Sickle Cell Centers, 71% of responding centers indicated antigen-
matching was done for all individuals with SCD, though a majority of respondents felt there was no clear consensus regarding appropriate practice in this regard. It is likely that centers that encounter smaller numbers of patients with SCD may not match for specific antigens, resulting in higher alloimmunization rates, though Management Guidelines produced by consensus and published by the National Institutes of Health’s Heart Lung and Blood Institute (last updated in 2002) state that for patients with SCD requiring transfusion “limited matching for E, C, and Kell antigens is usually performed, unless patients have antibodies”. However, a survey suggests that in 2003 only a minority of blood banks phenotyped red blood cells for certain non-ABO antigens for transfusions given to individuals with SCD prior to immunization. Those blood banks that screened provided blood compatible at C, E and K antigens most commonly, with some blood banks matching for additional antigens based on the patient’s red cell phenotype. Though the patients in PROACTIVE were being seen at SCDCRN centers, some may have also been seen at other hospitals in their community that do not adhere to the same policies as those in specialty centers, and thus be exposed to antigens that put them at high risk of alloimmunization. That only 18 subjects had detectable antibodies on screening enrollment to PROACTIVE while 34 had an antibody history emphasizes the need for complete transfusion histories; alloantibody strength can diminish over time, ultimately causing the antibody to become undetectable.

Eleven (45.8%) of the survey responders that did antigen matching attempted to exclude exposure to Duffy antigens. Of those sensitized at entry to or during the CSSCD, 18.3% of antibodies were to Fya and 4.7% to Fyb; 14.7% of the antibodies reported in PROACTIVE were to a Duffy antigen. In addition to being a portal of entry for the malarial parasite and thus uncommon in Africans and those of African ancestry, Duffy antigen has also been proposed as a cytokine sump, provision of which through transfusion might theoretically attenuate the course of ACS; it is also of interest that a “masking mutation” (GATA) suppresses expression of Duffy antigen on erythroid cells while permitting expression on other somatic cells, reducing the likelihood of alloimmunization of affected Fy(a-b-) patients if transfused Fy(b+) cells. The SCDCRN had hoped to assess the potential therapeutic impact of transfusion of Duffy positive cells as a secondary endpoint but failed to accrue adequate numbers of transfused patients. One hundred forty of 155 (90%) patients with red cell phenotype available were Fya negative, 132 of 153 (86%) were Fyb negative and 123 (80%) were negative for both Duffy antigens, apparently even somewhat higher than that previously reported for African Americans (68%). We have thus confirmed the high prevalence of Duffy negativity in people with SCD, but also a moderate prevalence of allosensitization. A prospective trial is needed to further explore the risks/benefits of transfusing Duffy negative patients with Duffy positive blood.

In conclusion, PROACTIVE data demonstrate that transfusion is commonly used to treat SCD today. Based on our PROACTIVE survey, it appears antigen matching for C, E, and often additional antigens for red cell transfusion is standard practice at most sickle cell centers today. The nearly universal use of red cell phenotyping and antigen matching at SCDCRN centers appears to have had modest, if any, impact on alloimmunization prevalence. Since we speculate that patients are in large part developing alloantibodies because they are seen at hospitals that do not proactively antigen match, it is important that
this practice be considered standard of care for all patients with SCD who require transfusion.

Acknowledgments

This publication was made possible by Grant Number U10HL083721 from the National Heart, Lung, and Blood Institute, National Institutes of Health. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the National Institutes of Health.

In addition to the authors of this manuscript, the following individuals were instrumental in the planning, conduct and/or care of patients enrolled in this study at each of the participating institutions as follows:

Aflac Cancer Center and Blood Disorders Service, Emory University School of Medicine and Children’s Healthcare of Atlanta, Atlanta, GA: Peter A. Lane, MD, Tamara N. New, MD, Terrell Faircloth, CCRC

Boston Medical Center, Boston, MA: Lillian E. C. McMahon, MD, Asif I. Qureshi, MD

Children’s Hospital Boston, Boston, MA: Matthew M Heeney, M.D, Meredith Anderson; For GCRC-supported studies: “This project was funded in part by grant MO1-RR02172 from the National Center for Research Resources, National Institutes of Health, to the Children’s Hospital Boston General Clinical Research Center.” Abbreviations may include NCRR, NIH, and GCRC.

Division of Hematology, Brigham and Women’s Hospital, Boston, MA: Maureen Okam, MD, MPH

Children’s Hospital of Philadelphia, Philadelphia, PA: Kwaku Ohene-Frempong, MD, Kim Smith-Whitley, MD; Clinical and Translational Research Center, Children’s Hospital of Philadelphia, CTRC grant number UL1-RR-024134

St. Christopher’s Hospital for Children, Philadelphia, PA: Norma B. Lerner, MD, MPH, Michele Cahill, RN, MaryLou MacDermott, CRNP, Maureen Meier, RN, CCRC

Division of Pediatric Hematology/Oncology, Al DuPont Hospital for Children, Wilmington, DE: Robin Miller, MD, Lynn Marts, BS, RN, CCRC

Division of Pediatric Hematology/Oncology, University of Louisville, Louisville, KY: Salvatore Bertolone, MD, Ashok B. Raj, MD

Center for Sickle Cell Disease and Department of Medicine, Howard University, Washington, DC: Victor R. Gordeuk, MD, Oswaldo L. Castro, MD Georgetown-Howard Universities Center for Clinical and Translational Science and supported by the National Institutes of Health National Center for Research Resources, Grant U54 RR026076

Children’s National Medical Center, Washington, DC: Lewis L. Hsu, MD, PhD

Children’s Hospital & Research Center, Oakland, CA: Mark Walters, MD

University of Illinois at Chicago, Chicago, IL: Richard J. Labotka, MD, Robert Molokie, MD, Sandra Gooden, RN, Daisy Pacelli, MPH, RN, Lani Krauz, RN

Children’s Memorial Hospital, Chicago, IL: Alexis A. Thompson, MD

Virginia Commonwealth University, Richmond, VA: Wally R. Smith, MD, Kamar Godder, MD, MPH

Johns Hopkins University School of Medicine, Baltimore, MD: James F. Casella, MD, Jeffrey Keefer, MD, PhD, Sophie Lanzkron MD, MHS, Cedron Williams, Phillip Seaman; Johns Hopkins University: Johns Hopkins Institute for Clinical and Translational Research; grant # U10 HL083721.

University of North Carolina at Chapel Hill, Chapel Hill, NC: Kenneth I. Ataga, MD, Susan K. Jones, RN, Dell Strayhorn, FNP, MPH, Teresa Escovitz; UNC Clinical and Translational Science Award,” grant # UL1RR02574

University of Mississippi Medical Center, Jackson, MS: Rathi V. Iyer, MD, Mary Gail Smith, MD, Carolyn Bigelow, MD, Suvankar Majumdar, MD, Glenda Thomas, RN, Arleen Anderson, RN

Medical College of Georgia, Atlanta, GA: Abdullah Kutlar, MD, Leigh Wells, RN, MSN, Latanya Bowman, Fritam Bora

Transfusion. Author manuscript; available in PMC 2016 November 04.
Wayne State University, Detroit, MI: Paul Swerdlow, MD
Duke University Medical Center, Durham, NC: Marilyn J. Telen, MD, Laura M. De (space) Castro, MD, Shital Kamble, PhD, Shelby Reed, PhD, Courtney D. Thornburg, MD, Hai Huang, Jade Jonassaint, RN
New York Methodist Hospital, Brooklyn, NY: Rita Bellevue, MD, Emmely M. Colon, Herold Duroseau, MD, Deepak Kilari, MD, Charlene Webb, LPN
Interfaith Medical Center, Brooklyn, NY: Edouard Guillaume, MD, Rafat Ahmed, MD, Miren Blackwood, Huguette Souffrant, Hossam Awad
Cincinnati Children’s Hospital Medical Center, Cincinnati, OH: Karen Kalinyak, MD, Clinton H. Joiner, MD, PhD
Ohio State University, Adult Sickle Cell Program Columbus, OH: Eric H. Kraut, MD, Leslie Witkoff, RN
Nationwide Children’s Hospital, Columbus OH: Melissa M. Rhodes, MD, Kami Perdue, CRA
Protocol Review Committee: (Chair) George Buchanan, MD, Ronald Brown PhD, Thomas D. Coates, MD, Violet Dease, MSW, Sophie Lanzkron, MD, Anita Tarzian, PhD, H. Knox H. Todd, MD, MPH, Mark Udden, MD, Sylvia Wassertheil-Smoller, PhD, David Wright PhD
New England Research Institutes, Watertown, MA: Sonja M. McKinlay, PhD, Beatrice Files, MD, Liyuan Huang, MS, David Brazier, PMP, Kristin K. Snow, MSc, ScD, Margaret C. Bell, MS, MPH
National Heart, Lung, and Blood Institute, Bethesda, MD: Harvey Luksenburg, MD, Henry Chang, MD, Liana Harvath, PhD, Myron Waclawiw, PhD
Data and Safety Monitoring Board Members: (Chair) Ted Wun, MD, FACP, Amy Becker, MD, Lennette Benjamin, MD, Susan Claster, MD, Michael Farrell, MD, Allison A. King, MD, MPH, Jeannette Y. Lee, PhD, Robert P. McMahon, PhD, Julie A. Panepinto, MD, MSPH

Finally, the SCDCRN thanks the individuals who participated in the PROACTIVE Feasibility trial and their families.

References


<table>
<thead>
<tr>
<th>Number of prior red cell transfusions</th>
<th>2–9 years (N=44)</th>
<th>10–17 years (N=78)</th>
<th>18–35 years (N=92)</th>
<th>36+ years (N=22)</th>
<th>Total (N=236)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of patients with alloantibody (N=3)</td>
<td>Number of patients (%</td>
<td>Number of patients with alloantibody (N=11)</td>
<td>Number of patients (%</td>
<td>Number of patients with alloantibody (N=15)</td>
</tr>
<tr>
<td>None</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>22</td>
<td>0</td>
</tr>
<tr>
<td>1–5</td>
<td>2</td>
<td>20 (45.5)</td>
<td>7</td>
<td>36 (46.2)</td>
<td>3</td>
</tr>
<tr>
<td>5–10</td>
<td>0</td>
<td>5 (11.4)</td>
<td>1</td>
<td>13 (16.7)</td>
<td>4</td>
</tr>
<tr>
<td>&gt;10</td>
<td>1</td>
<td>5 (11.4)</td>
<td>3</td>
<td>12 (15.4)</td>
<td>7</td>
</tr>
</tbody>
</table>