In March 2014, an outbreak of a febrile illness associated with a high case fatality rate was identified in the Guéckédou region of Guinea–Conakry, a remote part of West Africa. An international field investigation was initiated. On April 16, the Journal published a preliminary report identifying the outbreak as due to Ebola virus. The initial sequence data showed that the outbreak strain was *Zaire ebolavirus*, but a strain distinct from those identified in prior outbreaks, such as those in the Democratic Republic of Congo (DRC) and Gabon. In Guinea there appeared to be ongoing human-to-human transmission. Over the next 4 to 8 weeks, the outbreak seemed to be resolving, as over 20 previous outbreaks have, with a substantial decline in new cases. We and others thought it would soon be over.

We were wrong. Cases started to appear over the summer, and the number increased exponentially as this viral infection spread more widely in Guinea–Conakry and in Liberia and Sierra Leone. Cases associated with travel have been identified in Senegal and Nigeria, and there is evidence of ongoing transmission in Nigeria. Recently, Ebola transmission has been identified in the DRC, although molecular data suggest that this event is unrelated to the ongoing West African outbreak. These molecular data provide the information we need to define important aspects of ongoing transmission dynamics and to guide control strategies. Currently, there is no effective treatment, but human vaccine trials have been initiated.

As of September 18, 2014, there were 5335 identified cases of Ebola virus disease, with more than 2622 associated deaths, which is more than in all previous Ebola outbreaks combined. These numbers are nonetheless likely to be underestimates, given the limitations of case identification, and the fraction of deaths probably underestimates the case fatality rate, because the interval between case identification and death has been just over 2 weeks. Although clinical data remain sparse, it seems likely that effective basic supportive care may make the difference between life and death for an infected patient. Unfortunately, health care workers have been disproportionately affected owing to the tremendous demands of patient care and the difficulty of implementing the infection-control measures required to prevent transmission. The Ebola outbreak is having serious adverse effects on
Transfusion Threshold of 7 g per Deciliter — The New Normal

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Holst and colleagues\(^1\) now provide definitive evidence in the *Journal* that a restrictive approach to blood transfusion not only reduced blood use by half but also did not cause harm to 998 critically ill patients with septic shock. It has been 15 years since the publication of the results of the Transfusion Requirements in Critical Care (TRICC) trial in the *Journal*.\(^2\) In that Canadian Critical Care Trial Group study, 838 critically ill patients were randomly assigned to receive blood transfusions on the basis of a threshold of 7 g per deciliter or 10 g per deciliter while also agreeing to undergo transfusion 1 unit at a time. Much like the results of the Transfusion Requirements in Septic Shock (TRISS) trial by Holst et al., approximately 50% less blood was administered in the restrictive-strategy group than in the liberal-strategy group. In contrast to this latest trial, overall trends and all the secondary analyses suggested that a liberal transfusion strategy may have resulted in increased mortality, increased rates of pulmonary edema, and increased rates of organ failure.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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