

# Blood Transfusion

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# RATIONALE FOR TRANSFUSION

- ▶ Blood delivers oxygen to the tissues, and the vast majority of oxygen delivered is bound to hemoglobin in RBCs.
- ▶ The major physiologic considerations relevant to anemic patients are the **degree to which oxygen delivery to the tissues is adequate** and whether **compensatory mechanisms for maintaining oxygen delivery will become overwhelmed or deleterious** .
- ▶ (AFTER **INCREASING** tissue oxygen **delivery** by **INCREASING CARDIAC OUTPUT** over a range of hemoglobin concentrations)

# Normal physiology

- ▶ Delivery of  $O_2$  = cardiac output “ STROKE VOLUME\*HEART RATE” x arterial oxygen content
- ▶ At rest, there is a large reserve in oxygen delivery, since the rate of delivery normally exceeds consumption by a factor of four.
- ▶ Thus, if intravascular volume is maintained during bleeding and cardiovascular status is not impaired, oxygen delivery theoretically will be adequate until the hematocrit falls below 10 percent.

because :

greater cardiac output

rightward shift of the oxygen-hemoglobin dissociation curve

increased oxygen extraction

can compensate for the decrease in arterial oxygen content

# Mechanisms that increase arterial oxygen content

Increased production of erythropoietin → hemoglobin synthesis

Rightward shift of oxyhemoglobin dissociation curve → increased O<sub>2</sub> delivery

# Mechanisms that increase cardiac output

Increased heart rate

Increased myocardial contractility

Decreased blood viscosity and decreased peripheral vascular resistance

## **DEFINITION**

- A Blood transfusion is the infusion of whole blood or blood components such as plasma, RBCs, or platelets into the venous system.

# PURPOSES

- ❖ To increase blood volume after surgery, trauma, or hemorrhage.
- ❖ To increase the number of red blood cells in a patient with severe chronic anemia.
- ❖ To provide platelets to patients with low platelet counts due to treatment with chemotherapy.
- ❖ To provide clotting factors in plasma for patients with hemophilia or disseminated intravascular coagulopathy (DIC).
- ❖ To replace plasma proteins such as albumin.
- ❖ To replace fresh frozen plasma in case of DIC.

# INDICATIONS

- Hemorrhage
- Trauma
- Burns
- Sever anemia
- Plasma proteins or clotting factor deficiency.
- Leukopenia
- Pathological conditions which result in decreased blood cells.



# CONTRAINDICATIONS

- Decreased cardiac output
- Active infection
- Fluid overload
- Renal failure

# RATE OF INFUSION FOR COMPONENTS OF BLOOD

PRODUCTS	INFUSION RATES
Whole blood and red blood cells	1 unit over 2-3 hours
platelets	30- 60 minutes
Fresh frozen plasma	200ml/hour or slowly
cryoprecipitate	1-2 ml/min

# RISKS AND COMPLICATIONS OF TRANSFUSION

- ▶ Infection is a risk of transfusion since transfusion-transmitted pathogens. In addition, some studies have reported that transfusion-mediated immunosuppression may lead to increased risk of postoperative bacterial infection and anastomosis leak.
- ▶ Allergic and immune transfusion reactions.
- ▶ Volume overload is typically a concern in the elderly, small children.
- ▶ Hyperkalemia from potassium released from RBCs during blood bank storage.
- ▶ Iron overload .

## Guidelines

AABB (formerly the American Association of Blood Banks), 2016

recommendations for hemodynamically stable patients without active bleeding

- ▶ Hemoglobin >10 g/dL – Transfusion generally not indicated except in exceptional circumstances.
- ▶ Hemoglobin 8 to 10 g/dL – Transfusion generally not indicated, but should be considered for some populations.
- ▶ Hemoglobin 7 to 8 g/dL – Transfusion may be appropriate in patients undergoing orthopedic surgery or cardiac surgery, and in those with stable cardiovascular disease.
- ▶ Hemoglobin 6 to 7 g/dL – Transfusion generally likely to be indicated.
- ▶ Hemoglobin <6 g/dL – Transfusion recommended except in exceptional circumstances.

- ▶ There is excellent clinical trial evidence that suggests that a restrictive policy of transfusion at a hemoglobin concentration of **7 to 8 g/dL should guide transfusion decisions in most patients.**
- ▶ The use of transfusion thresholds that restrict transfusion to this hemoglobin concentration are **safe in most patient populations**, may improve clinical outcomes, and will reduce unnecessary transfusion

- ▶ For most medical and surgical hospitalized hemodynamically stable patients, including those in the intensive care unit or with septic shock, it is recommended transfusion to maintain the hemoglobin at  $>7$  g/dL rather than a higher threshold (Grade 1B **EVIDENCE**)
- ▶ however there may be cases in which the patient is **asymptomatic at a hemoglobin of 7 g/dL**, and clinician judgment may **support not administering a transfusion**.

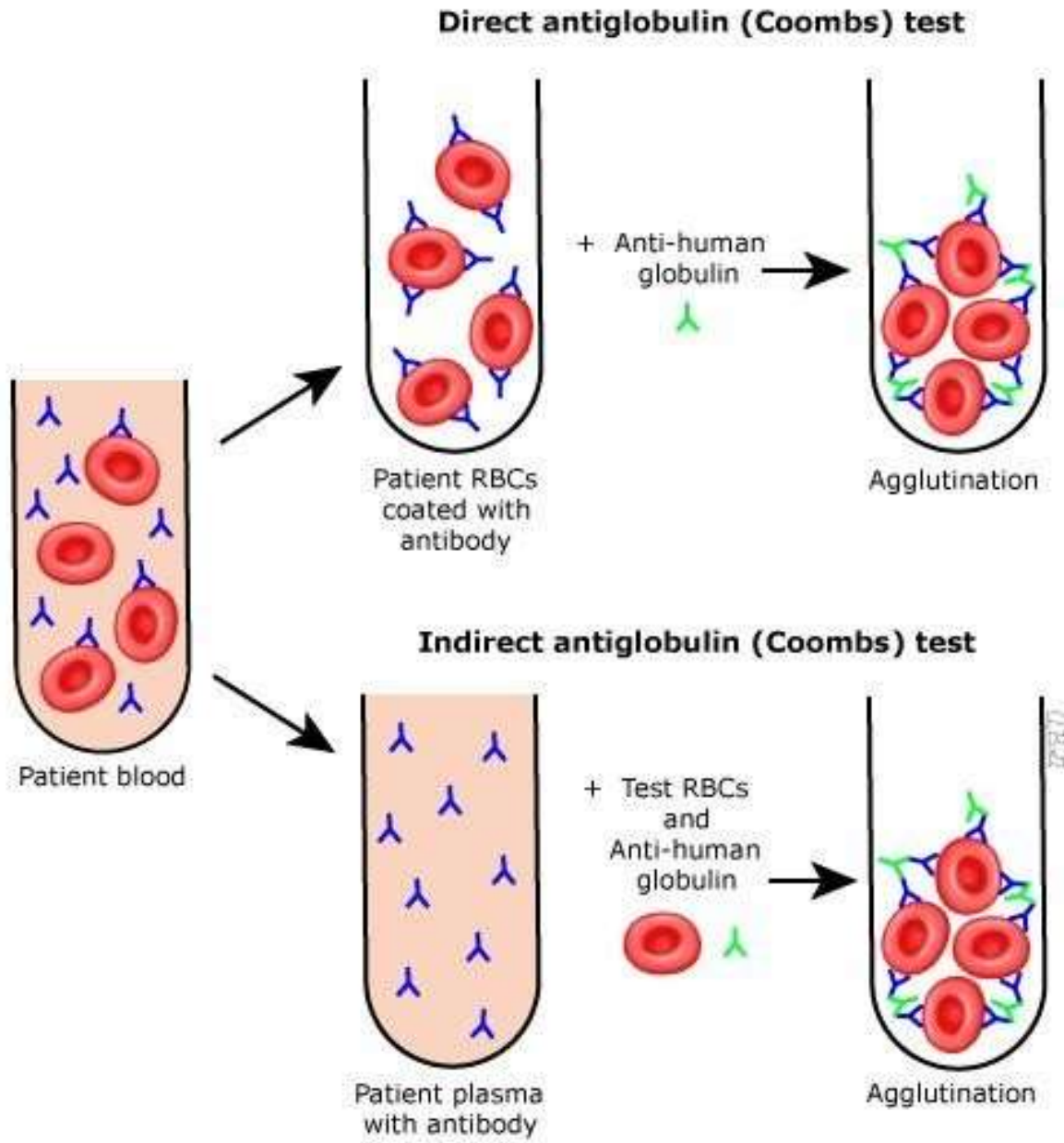
# Major exceptions to the use of a threshold of 7 to 8 g/dL

- ▶ Symptomatic patients below 10 mmhg .
- ▶ Patients with acute coronary syndromes have not been adequately evaluated in clinical trials .
- ▶ Threshold-based transfusion is not appropriate for patients requiring massive transfusion.
- ▶ Severe thrombocytopenia in hematology/oncology patients at risk of bleeding.
- ▶ Chronic transfusion-dependent anemia.

# PRE-TRANSFUSION TESTING

- ▶ **Antiglobulin (Coombs) testing**
- ▶ **Blood type** Blood type (also called blood group) refers to ABO and Rh(D) antigens expressed on an individual's RBCs
- ▶ **Crossmatch (compatibility testing)** – Crossmatch or compatibility testing refers to the selection and testing of a specific donor unit of RBCs for transfusion to the recipient.
- ▶ **Type and screen** – Type and screen refers to testing only on the recipient sample, including ABO and Rh(D) type and antibody screen





# Specimen collection tube

- ▶ In general, one 6 mL tube containing EDTA (eg, "pink top tube" or "purple top tube") is sufficient for all routine blood bank pre-transfusion testing, including type and screen and compatibility testing.
- ▶ Of note, hemolysis or lipemia may interfere with interpretation of agglutination due to color and/or cloudiness of the plasma.

# COLLECTION AND STORAGE PROCEDURES

- ▶ RBC are stored for up to 42 days
- ▶ for example citrate phosphate dextrose (CPD) for 21-day storage, CPD-adenine for 35-day storage, and the current generation of additive solutions that permit storage for 42 days.
- ▶ Regulations require that red cells be stored under refrigeration at controlled temperatures of 1 to 6°C to maintain the viability of the red cells and to prevent the growth of bacteria.

# Freezing to preserve rare RBC units

- ▶ RBCs frozen in 40 percent glycerol are approved by the FDA and the AABB for storage at -80°C for up to 10 years.
- ▶ The use of this product was evaluated in a prospective, randomized trial of 57 stable trauma patients who required blood transfusion . Compared with refrigerated RBC, frozen deglycerolized cells were noninferior with respect to increasing hematocrit, effects on thromboelastography parameters, and clinical outcomes.
- ▶ The need to subject red cells to glycerolization and freezing, and the time and effort required for thawing and washing immediately before infusion increases cost and delays transfusion. Thus, frozen deglycerolized red cells have a limited number of indications. These include the long-term storage of "rare" RBC units for transfusion of individuals with uncommon blood types

# **EFFECT OF STORAGE CONDITIONS ON TRANSFUSION OUTCOMES**

- ▶ **2,3 BPG concentration**
- ▶ **Potassium leakage**
- ▶ **Citrate**
- ▶ **Ammonia**
- ▶ **Nitric oxide**

# PACKED RBCs VERSUS WHOLE BLOOD

- ▶ When citrate-phosphate-dextrose adenine (CPD-A1) is the anticoagulant used (35 day storage), the hematocrit of the RBC unit is approximately 65 to 80 percent, and the usual volume is between 225 and 350 mL.
- ▶ When an additive solution (AS) system is used (42 day storage), virtually all of the plasma is removed and then replaced with approximately 100 mL of storage solution resulting in a hematocrit of approximately 55 to 65 percent and a volume of 300 to 400 mL.
- ▶ Whole blood should be considered only when treating an adult who has bled acutely and massively.

# Leukoreduced red cells

- ▶ HLA alloimmunization against class I antigens does not appear to occur if the red cell preparation contains less than  $1$  to  $5 \times 10^6$  leukocytes.
- ▶ Some patients experience febrile transfusion reactions that are due to white cell contamination of the red cell concentrate rather than RBC alloimmunization.
- ▶ Leukoreduction is an effective method to prevent (or at a minimum, markedly reduce) the risk of transfusion-transmitted cytomegalovirus infection. CMV resides in the leukocytes and is removed during leukoreduction

# Irradiated red cells

- ▶ In order to avoid the occurrence of graft-versus-host disease (GVHD) in patients who have immune deficiency states, transfused red cells must be subjected to irradiation with at least 25 Gy to prevent the donor T lymphocytes from dividing in the recipient.
- ▶ Irradiation to prevent “ GVHD “ is also recommended for red cells collected from relatives entered in directed donation programs



# Washed red cells to remove plasma

- ▶ In order to prevent or eliminate complications associated with infusion of proteins present in the small amount of residual plasma in red cell concentrates, the unit of blood can be washed immediately before infusion. This approach is indicated for the following conditions:
  - Patients with severe or recurrent allergic reactions ( hives) associated with red cell transfusion.
  - Certain patients with IgA deficiency when IgA deficient donors are not available (although frozen deglycerolized red cells may be the component of choice);

# INFUSION PARAMETERS

- ▶ **Consent**
- ▶ **Premedication**
- ▶ **Filters** – All RBC units must be transfused through a standard 170 to 260 micron filter (contained as an integral part of a standard infusion set) designed to remove clots and aggregates.
- ▶ **Compatible fluids** – No other intravenous solutions or medications except 0.9 percent sodium chloride for injection, ABO compatible plasma, or albumin should be administered through the same tubing concurrently with the RBCs.

# INFUSION PARAMETERS

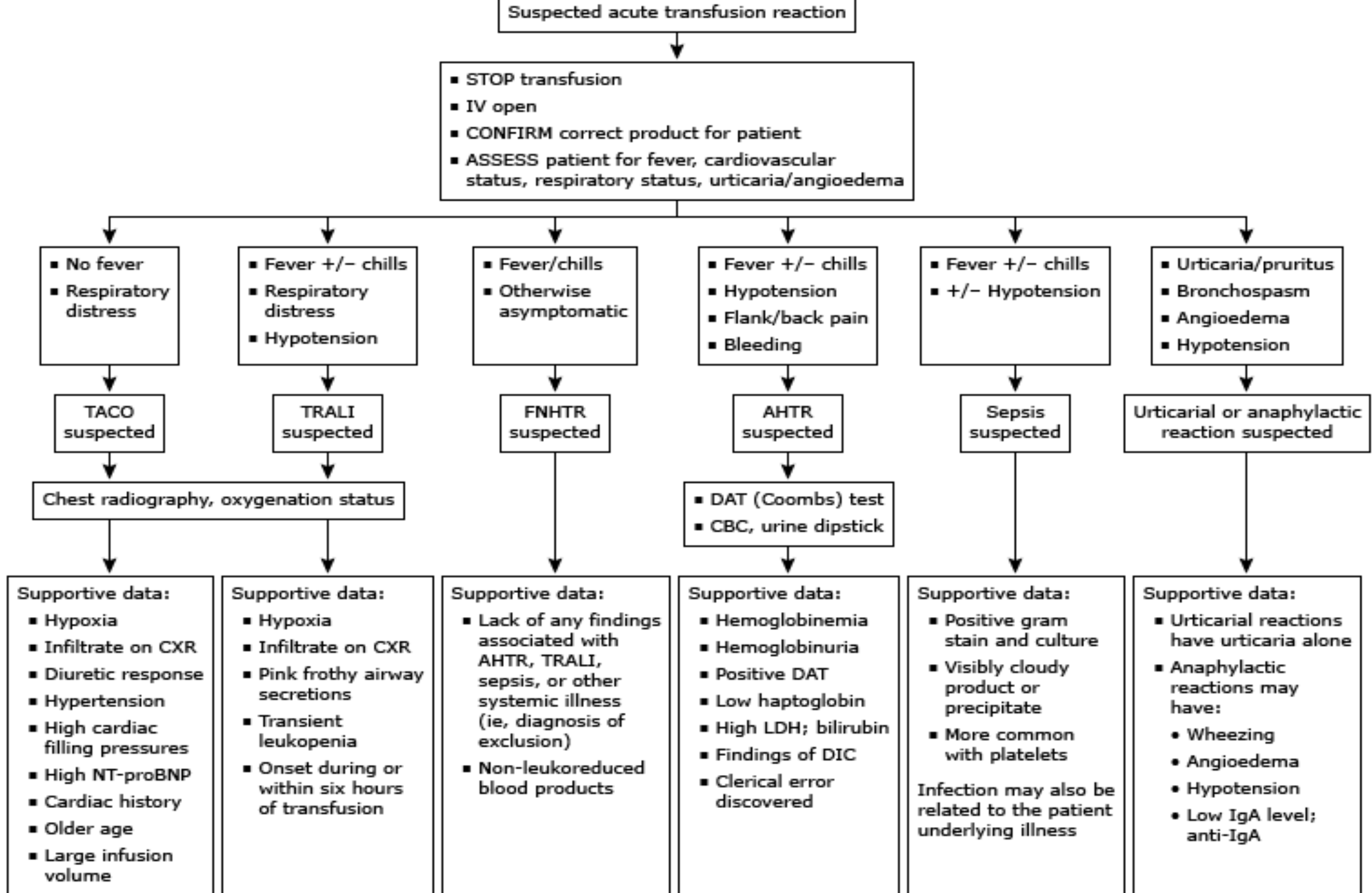
- ▶ **Infusion rate** – Suggested rates for adults are 1 to 2 mL per minute (60 to 120 mL per hour) for the first 15 minutes and then as rapidly as tolerated; the complete infusion should not exceed four hours.
- ▶ **Blood warmers** –blood warmers that raise the temperature closer to body temperature are used.
- ▶ **Post-transfusion hemoglobin level** – The post-transfusion hemoglobin level may be accurately measured as early as 15 minutes following transfusion.
- ▶ **Observation following transfusion** – In addition to observing the patient during transfusion, inpatients will continue to be observed for 15 to 30 minutes post-transfusion.

# Transfusion Reaction

The background of the slide is white with abstract green geometric shapes on the right side. These shapes include overlapping triangles and polygons in various shades of green, from light lime to dark forest green. A thin, light gray line runs diagonally across the white space, starting from the bottom right and extending towards the top right.

Reaction	Clinical findings	Laboratory findings	Implicated products and findings
Acute hemolytic reaction	Fever, chills, hypotension, back pain, DIC	Hemoglobinemia, hemoglobinuria, positive direct anti-globulin (Coombs) test (may be negative if all cell have hemolyzed), findings of DIC (prolonged PT, prolonged aPTT, low fibrinogen, thrombocytopenia)	RBCs, plasma (much less common), rarely platelets Intended recipient does not match actual recipient
Anaphylactic reaction	Hypotension, angioedema, wheezing, respiratory distress	Hypoxemia, IgA deficiency, anti-IgA	RBCs, platelets, plasma products
Acute lung injury (TRALI)	Respiratory distress, hypotension	Abnormal chest radiography, hypoxemia, transient leukopenia, anti-neutrophil or anti-HLA antibodies (if tested)	RBCs, platelets, plasma products
Circulatory overload (TACO)	Respiratory distress, rales	Abnormal chest radiography, hypoxemia, increased BNP or NT-proBNP	RBCs, platelets, plasma products
Sepsis/bacterial infection	Fever, chills, hypotension, DIC	Bacteremia, leukocytosis, findings of DIC	Platelets most commonly implicated, but can be any product Product may show bacterial contamination
Febrile non-hemolytic reaction	Fever	None	All blood products, but plasma is much rarer
Urticarial reaction	Hives	None unless specific	All blood products

Feature	TRALI	TACO transfusion-associated circulatory overload
Body temperature	Fever may be present	Unchanged
Blood pressure	Hypotension may be present	Hypertension may be present
Respiratory symptoms	Acute dyspnea	Acute dyspnea
Neck veins	Unchanged	May be distended
Auscultation	Rales	Rales and S3 may be present
Chest radiograph	Diffuse bilateral infiltrates	Diffuse bilateral infiltrates
Ejection fraction	Normal	Decreased
PAOP	Most often 18 mmHg or less	Greater than 18 mmHg
Pulmonary edema fluid	Exudate	Transudate
Fluid balance	Neutral or negative	Positive
Response to diuretics	Inconsistent	Significant improvement
White cell count	Transient leukopenia may be present	Unchanged
BNP	<250 pg/mL	>1200 pg/mL



# FEBRILE NONHEMOLYTIC REACTIONS

## FNHTR

- ▶ the most common of all transfusion reactions.
- ▶ more frequent in children than adults.
- ▶ They are most likely with platelets prepared from platelet-rich plasma (ie, whole blood-derived platelets, as opposed to apheresis platelets), since these platelet products have the highest concentration of leukocytes.
- ▶ **Mechanism of FNHTR** — FNHTRs are commonly caused
  - \* cytokines that are generated and accumulate during the storage of blood components.
  - \* have been associated with antibodies directed against class I HLA antigens present on leukocytes in red cell concentrates.
  - \* been associated with release of platelet-derived CD154 (CD40 ligand), which is capable of inducing production of proinflammatory cytokines



# Clinical presentation and diagnosis of FNHTR

- ▶ occur within one to six hours after initiation of a transfusion; these include fever, often a chill, occasionally severe rigors.
- ▶ The temperature increase is typically in the range of 1 to 2°C. A temperature increase of <1°C is not considered clinically significant, while an increase of >2°C is more suggestive of an acute hemolytic or septic transfusion reaction.
- ▶ FNHTRs are diagnosed clinically by excluding other causes of fever in a patient receiving a transfusion .
- ▶ **There is no laboratory or other testing that can confirm or exclude the presence of an FNHTR.**
- ▶ The extent of the evaluation for other causes depends on the severity of the temperature increase and the presence or absence of other symptoms. As an example, **a patient with fever, hypotension, and back pain should have a full evaluation for hemolytic transfusion reaction and possibly sepsis, whereas an individual with isolated mild fever may have a physical examination, clerical check of the transfusion, and visual inspection of the blood product.**

# Management of FNHTR

- ▶ Stopping of the transfusion.
- ▶ Administration of antipyretics if the fever is bothersome to the patient.
- ▶ Evaluation for other causes of fever, which include more serious (and potentially life-threatening) transfusion reactions as well as non-transfusion-related infection or fever.
- ▶ Administration of other medications, if needed, such as [meperidine](#) (25 to 50 mg) for severe chills or rigors.

# Prevention of FNHTR

- ▶ pre-storage leukoreduction of the product (ie, removing most of the white blood cells by passing the cellular blood products through a filter shortly after the collection or using an apheresis collection technology with effective leukoreduction).
- ▶ Do **not** use premedications (eg, [diphenhydramine](#), [acetaminophen](#)) to decrease the incidence of FNHTRs as they are ineffective and may cause adverse events on their own such as cardiovascular symptoms and central nervous system alterations.

## Diagnosis is made clinically

The most common signs and symptoms are cutaneous (eg, sudden onset of generalized urticaria, angioedema, flushing, pruritus). However, 10 to 20% of patients have no skin findings.

**Danger signs: Rapid progression of symptoms, respiratory distress (eg, stridor, wheezing, dyspnea, increased work of breathing, persistent cough, cyanosis), vomiting, abdominal pain, hypotension, dysrhythmia, chest pain, collapse.**

# Acute management

The first and most important treatment in anaphylaxis is epinephrine. There are **NO absolute contraindications to epinephrine in the setting of anaphylaxis.**

**Airway:** Immediate intubation if evidence of impending airway obstruction from angioedema. Delay may lead to complete obstruction. Intubation can be difficult and should be performed by the most experienced clinician available. Cricothyrotomy may be necessary.

Promptly and simultaneously, give:

**IM epinephrine (1 mg/mL preparation):** Give epinephrine 0.3 to 0.5 mg intramuscularly, preferably in the mid-outer thigh. Can repeat every 5 to 15 minutes (or more frequently), as needed. If epinephrine is injected promptly IM, most patients respond to one, two, or at most, three doses. If symptoms are not responding to epinephrine injections, prepare IV epinephrine for infusion (see below).

Place patient in recumbent position, if tolerated, and elevate lower extremities.

**Oxygen:** Give 8 to 10 L/minute via facemask or up to 100% oxygen, as needed.

**Normal saline rapid bolus:** Treat hypotension with rapid infusion of 1 to 2 liters IV. Repeat, as needed. Massive fluid shifts with severe loss of intravascular volume can occur.

**Albuterol (salbutamol):** For bronchospasm resistant to IM epinephrine, give 2.5 to 5 mg in 3 mL saline via nebulizer. Repeat, as needed.

# Treatment of refractory symptoms:

**Epinephrine infusion:** For patients with inadequate response to IM epinephrine and IV saline, give epinephrine continuous infusion, beginning at **0.1 mcg/kg/minute** by infusion pump<sup>Δ</sup>. Titrate the dose continuously according to blood pressure, cardiac rate and function, and oxygenation.

**Vasopressors:** Some patients may require a second vasopressor (in addition to epinephrine). All vasopressors should be given by infusion pump, with the doses titrated continuously according to blood pressure and cardiac rate/function and oxygenation monitored by pulse oximetry.

**Glucagon:** Patients on beta-blockers may not respond to epinephrine and can be given glucagon 1 to 5 mg IV over 5 minutes, followed by infusion of 5 to 15 mcg/minute. Rapid administration of glucagon can cause vomiting.

# ANAPHYLACTIC TRANSFUSION REACTIONS

- ▶ Rare but serious.
- ▶ Anaphylaxis results from sudden (typically massive) systemic release of mediators such as histamine and tryptase by mast cells and basophils, typically in response to an IgE-mediated (or IgG-mediated) immune reaction.

# Clinical presentation and diagnosis of anaphylactic reactions

- ▶ Anaphylactic transfusion reactions are of rapid onset (as are all anaphylactic reactions), typically occurring within a few seconds to a few minutes following initiation of a transfusion. The patient may experience shock, hypotension, angioedema, respiratory distress, and/or wheezing.

- ▶ Diagnosis made clinically .

quantitative measuring of IgA levels as well as anti-IgA (if indicated), preferably on a pre-transfusion sample. Mast cell tryptase can be measured if the test is but the results generally do not alter diagnosis or management when the clinical diagnosis appears obvious.

Similarly, a chest radiograph could help distinguish between pulmonary edema and bronchospasm if these cannot be differentiated clinically.



# URTICARIAL (ALLERGIC) REACTIONS

- ▶ Urticarial (allergic) reactions, characterized by hives without other allergic findings, are one of the most common transfusion reactions.
- ▶ urticarial transfusion reactions occur when a soluble substance in the plasma of the donated blood product (or the recipient) reacts with pre-existing IgE antibodies in the recipient (or the product)
- ▶ A commonly cited example of urticarial reactions is donor peanut allergy, with hives in the recipient triggered by recent peanut ingestion by the recipient.

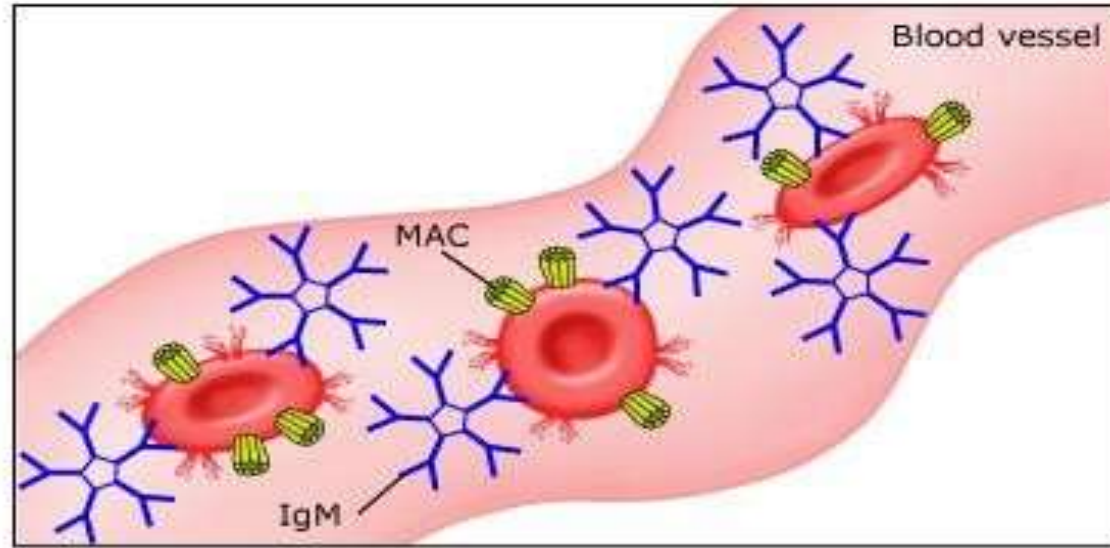
# Management and prevention of urticarial reactions

- ▶ the transfusion should first be stopped, and, if the urticaria is extensive, 25 to 50 mg of [diphenhydramine](#) can be given orally or intravenously. If the urticaria wanes and there is no evidence of dyspnea, hypotension, or anaphylaxis, the transfusion may be resumed.

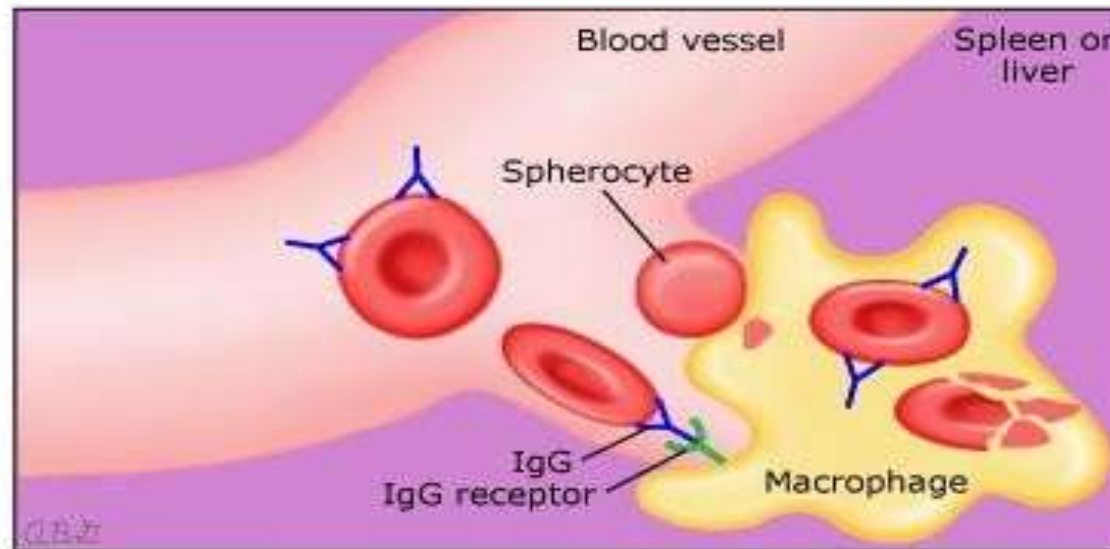
# HEMOLYTIC TRANSFUSION REACTIONS

- ▶ Hemolytic transfusion reactions (HTRs) are characterized by immune-mediated red blood cell (RBC) destruction (hemolysis).
- ▶ They can be acute (during or within 24 hours after a transfusion) or delayed (days to weeks after a transfusion); and the hemolysis can be intravascular (releasing free hemoglobin into the circulation) or extravascular (resulting in removal of RBCs by the reticuloendothelial system)

**A** Intravascular hemolysis



**B** Extravascular hemolysis



# AHTR

## Acute HTRs (AHTRs) are hemolytic reactions

- ▶ occur during the transfusion or within 24 hours of completing the transfusion.
- ▶ AHTRs are typically associated with rapid intravascular hemolysis, which can lead to acute renal failure, disseminated intravascular coagulation (DIC), and hemodynamic collapse.
- ▶ the classic AHTR is a medical emergency requiring immediate intervention.
- ▶ Typical symptoms and findings include fever, chills, back or chest pain, and pink/red serum, plasma or urine, although the full "classic triad" of fever, flank pain, and red urine is rarely seen.
- ▶ In a patient under anesthesia or in a coma, evidence of DIC (oozing from intravenous catheter sites) may be the only finding.
- ▶ AHTRs are most commonly seen in the setting of ABO blood group incompatibility .

# DHTR – Delayed HTRs (DHTRs) are hemolytic reaction

- ▶ occur more than 24 hours after completing the transfusion.
- ▶ Often, they occur days to weeks later.
- ▶ DHTRs are typically gradual and less severe; sometimes they are clinically silent.
- ▶ Laboratory findings may include a mild increase in anemia (or failure of the hemoglobin to increase as expected after transfusion) and evidence of extravascular hemolysis, which may include spherocytes on the peripheral blood smear.
- ▶ DHTRs almost always result from an anamnestic response following re-exposure to a foreign RBC antigen such as one from Rh system. Previous exposure may have occurred through transfusion or pregnancy.
- ▶ DHTRs generally do not require any treatment except for future avoidance of transfusions containing the implicated RBC antigen. If a DHTR is accompanied by more brisk hemolysis, more aggressive treatment may be required (ie, as for AHTR).

\*anamnestic response. renewed rapid production of an antibody on the second (or subsequent) encounter with the same antigen

# Management

- ▶ If the initial bedside evaluation (or subsequent testing) is consistent with intravascular hemolysis :

normal saline should be infused immediately to reduce the risks of hypotension and renal injury. An infusion rate of 100 to 200 mL/hour is typically used to support a urine output above 1 mL/kg/hour or 100 to 200 mL/hour to reduce the likelihood of acute oliguric renal failure .

The beneficial effect of urinary alkalinization in patients with marked hemoglobinuria is uncertain.

Vasopressors may be required to treat hypotension.

A nephrologist may be consulted for advice on prophylactic measures to prevent or reduce renal damage and in some cases to treat severe hyperkalemia

# Management

- ▶ Repeat ABO compatibility testing.
- ▶ Additional antibody studies if ABO incompatibility is excluded.
- ▶ Repeat crossmatch .
- ▶ Direct antiglobulin (Coombs) testing (DAT), which may be positive in AHTR but may be negative in ABO incompatibility or if hemolysis is so severe that all RBCs with antibody on the surface have been lysed.
- ▶ Visual inspection of the serum and urine for pink or dark brown color. The serum should be analyzed for free hemoglobin, and a urine sample should be saved in case analysis of the urine for free hemoglobin is required. Pink or dark brown serum and/or urine and a positive test for free hemoglobin will be present in severe intravascular hemolysis but not in extravascular hemolysis.
- ▶ ●Testing for hemolysis with serum haptoglobin, lactate dehydrogenase (LDH), and unconjugated (indirect) bilirubin levels. In hemolysis, haptoglobin will be low; LDH and bilirubin will be increased, although the increase in unconjugated bilirubin may be delayed and is more likely to be helpful in evaluating the patient for a DHTR than for an AHTR.
- ▶ ●Testing for DIC if the patient has obvious signs of intravascular hemolysis (eg, pink serum or urine, hypotension) or signs of DIC such as oozing from intravenous sites or increased bleeding; DIC is a sign of severe intravascular hemolysis.
- ▶ ●Electrolyte testing and cardiac monitoring if the patient has obvious signs of intravascular hemolysis, since lysis of RBCs releases potassium into the circulation and may cause severe hyperkalemia.
- ▶ Serial hemoglobin levels,



# Differential diagnosis of AHTR

- ▶ Oxidative damage
- ▶ Immune hemolysis
- ▶ Autoimmune hemolytic anemia (AIHA) ([Warm agglutinins and drugs](#))
- ▶ Direct red cell destruction

# Massive transfusion

- ▶ defined as the replacement by transfusion of 10 units of red cells in 24 hours, is a response to massive and uncontrolled hemorrhage.
- ▶ With more rapid and effective therapy, alternative definitions such as three units over one hour are more sensitive in identifying patients needing rapid issue of blood products for serious injuries because of uncontrolled hemorrhage.

- ▶ as volume is replaced, attention must be paid to coagulation parameters, platelet count, and metabolic status.
- ▶ preferably after each five units of blood replaced. If the PT and aPTT exceed 1.5 times the control value, the patient should be transfused with at least two units of fresh frozen plasma. If the platelet count falls below 50,000/microL, six units of random donor platelets, or one unit of apheresis platelets, should be given.
- ▶ Acid-base balance and the plasma ionized calcium and potassium levels should be periodically monitored, particularly in patients with coexistent liver or renal disease or in those with massive hemorrhage and low cardiac output.
- ▶ If 10 percent [calcium gluconate](#) is used, 10 to 20 mL should be given intravenously (into another vein) for each 500 mL of blood infused.

# Platelet transfusion

- ▶ A unit of platelets isolated from a unit of donated blood contains approximately  $7 \times 10^{10}$  platelets, and four to six of these units are typically pooled for transfusion.
- ▶ Single donor (apheresis) platelets contain approximately  $3$  to  $6 \times 10^{11}$  platelets (ie, the equivalent of six or more units) per unit.
- ▶ Platelets are stored at room temperature; consequently their shelf life is only approximately five days
- ▶ Platelet transfusion can be lifesaving in bleeding patients with thrombocytopenia or reduced platelet function. Platelets should be transfused in any patient who is bleeding with a platelet count  $<50,000/\text{microL}$  ( $100,000/\text{microL}$  for central nervous system or ocular bleeding), or in any patient with an acquired or inherited platelet function defect regardless of platelet count

- ▶ It is used as a prophylactic platelet transfusion to prevent spontaneous bleeding in most hospitalized afebrile patients with platelet counts below 10,000/microL due to bone marrow suppression.
- ▶ Patients with acute promyelocytic leukemia (APL) have a coexisting coagulopathy, and it is used a platelet transfusion threshold of 30,000 to 50,000/microL in these patients
- ▶ Platelets should not be used to treat thrombocytopenia due to platelet destruction such as TTP, ITP, HUS, HELLP syndrome, etc.

# Dosage

- ▶ The volume of a dose of platelets is approximately 350-400mL. The initial recommended dose for an adult is 6 units of pooled random donor platelets of one apheresis unit; for pediatrics, the dose is 5-10mL/kg. This dose will usually increase the platelet count by approximately 25K-35K/microliter.

# Plasma

- ▶ Fresh Frozen Plasma (FFP) – Plasma frozen within eight hours of collection
- ▶ •Plasma Frozen Within 24 Hours After Phlebotomy (PF24) – Plasma frozen within 24 hours of collection; also called Frozen Plasma
- ▶ •Thawed Plasma – Plasma that was frozen (ie, FFP or PF24), thawed, and kept at refrigerator temperature for up to five days

# Plasma

- ▶ FFP, PF24, and Thawed Plasma are indicated for correction of major bleeding or in preparation for invasive procedures when the INR is substantially elevated.
- ▶ Plasma products should not be used as a source of albumin or nutrients, as a volume expander, or to correct a minimally elevated INR (ie, <2.0).
- ▶ Plasma generally is administered intravenously at a dose of 10 to 15 mL/kg of body weight..
- ▶ Due to the normal presence of A and/or B alloantibodies in patients with blood types A, B, and O, donor plasma must be either **ABO-identical** or **ABO-compatible** with the recipient.
- ▶ ●Risks of exposure to plasma include infection; volume overload (TACO); and febrile, allergic, anaphylactic, transfusion reactions, and transfusion-related acute lung injury (TRALI).



# Cryoprecipitate

- ▶ Cryoprecipitate contains fibrinogen (factor I), factor VIII, fibronectin, factor XIII, and von Willebrand factor (VWF).
- ▶ ●Cryoprecipitate can be provided as single units or as "pools" containing five or more units.. In the average patient, each unit raises the plasma fibrinogen concentration by approximately 7 to 10 mg/dL; thus, 10 units will raise the fibrinogen by approximately 70 to 100 mg/dL in a 70 kg.
- ▶ cryoprecipitate carries risks of various types of transfusion reactions/complications.

**THANK YOU**