When to challenge requests for blood components, and why - the clinician's perspective

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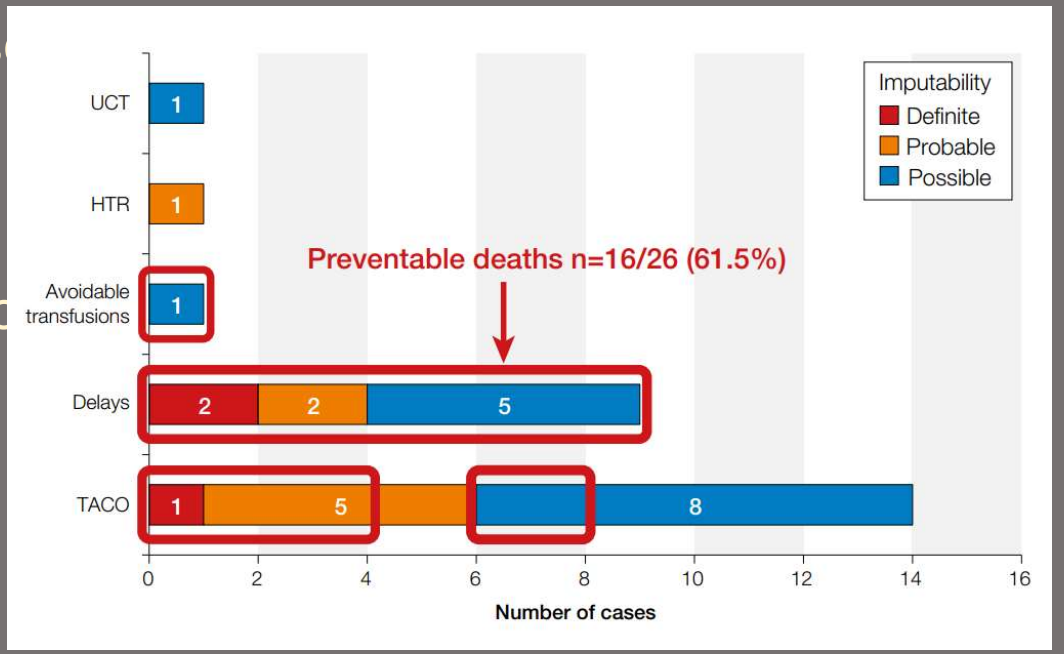
Why challenge requests?

- Unsafe practice
  - many products are demonstrably harmful and more restrictive use is recommended
- Deviation from guidance or licens
- To prevent waste
- To pick-up and prevent mistakes
- To identify potential alternatives c
- To educate yourself and others



Reasons challenges may be unwelcome

- Delay emergency treatment
- Adding to workload
  - 2nd x-match, post-transfusion increment, repeat tests
- Inconsistent advice
- Perceived different priorities
  - patient care vs financial imperatives
  - undertreatment vs adverse effects
- Repetition
  - of clinical information, or tasks
- Requesters often themselves not empowered
- Personality issues

Causes of conflict

- Inadequate information about the case
  - not available, and not shared
- Inadequate knowledge of evidence, good practice and guidelines
- Inconsistent advice received
- Presumption in favour of intervention
- Often subordinates liaising with each other

- Many conflicts can and should be prevented by departments agreeing protocols at a senior level

Timing

Consider challenging requests when for:

- elective or prophylactic use
- high cost products
- off-license, or where specific guidance contradicts

Don’t challenge when there is:

- acute haemorrhage (for RBCs)
  - even if you haven’t had an up-to-date Hb etc.
  - See Shackelford 2017 – OR 0.39 for 30 day survival in military trauma
- requests for immediate O-(+)
- when a delay in supply will further impact (e.g. delaying critical procedures)

Specific cases

- FFP for liver patients pre-procedure
  - Not recommended where INR < 2.0
  - INR of FFP is ~1.6
  - A dose of 4 units required to get 10-20% increase in factors
  - These patients typically having ERCP or PTC, with little ability to surgically control bleeding
- Plts pre-LP, or for 'reversal' of antiplatelet drugs
  - 2016 BCSH guidance recommend a threshold of 20 for central lines, 40 for LP, 80 for epidural (and spinal) anaesthesia
  - Limited efficacy in reversing antiplatelets. Depends on timing of last dose and drug. See PATCH trial Lancet 2016 **387**:2605-2613 for harm in haemorrhagic stroke
  - Consider tranexamic acid

Specific cases

- RBC for radiotherapy patients
  - Much observational data suggests that cervical cancer patients undergoing radiotherapy do better with higher (up to >120g/L) Hb
  - More limited data for other cancers
  - No randomised data, and some obvious confounders
- RBC pre-op
  - Pre-operative anaemia is best managed with iron/EPO in most cases
  - Post-op transfusion trigger 70g/L (red book, TRICC trial 1999)

Specific cases

- PCC for Xa/II inhibitors
  - Unlicensed, expensive, little public data on efficacy
  - Possible thrombotic risk, and the drugs themselves often already excreted
- Odd requests: IgA negative blood
  - May reflect historical practice, or patient preference
  - Largely excluded by NHSBT policy
- Lack of understanding about blood bank processes with e.g. pan-auto

Aims

- Avoid issuing inappropriate products to prevent harm
- Identify patterns of requesting that fall outside guidelines to improve future requesting and supply
- Longer-term feeding back to requesters
  - via the online requesting system (if applicable) - automatic
  - hospital transfusion committee
  - summoning clinicians to account for their practice