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Transfusion within the Obstetric and Gynaecology department in a busy District General Hospital, and the changes seen after publishing a new policy on anaemia management.

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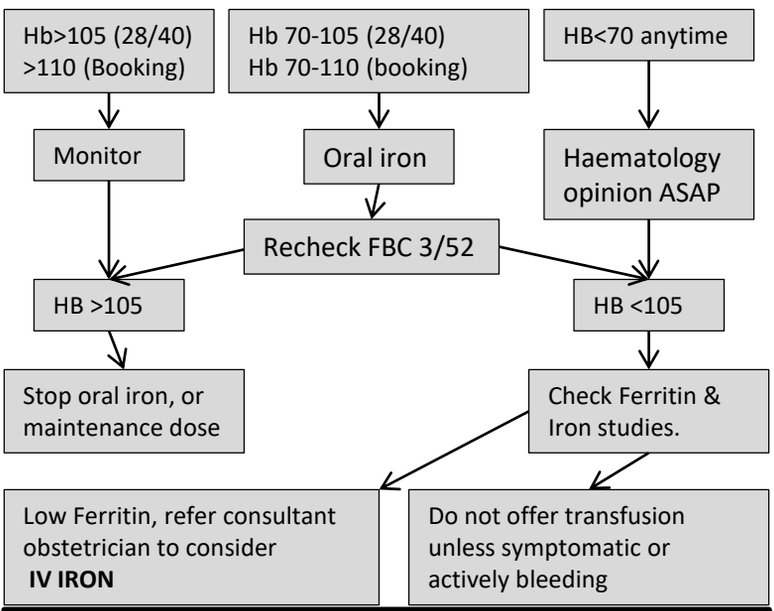
Transfusion within women of childbearing age remains a key target due to the risk of developing red cell antibodies, which can occur in as many as 10% people after a single transfusion, and can be a cause of foetal morbidity and mortality in future pregnancies. Haemolytic disease of the foetus or newborn affects 1 in 21,000 births, and presents a great mental cost to patients and financial cost to the NHS. In Jan 2017 a new policy on the management of anaemia within this population was published. This audit seeks to assess whether the policy has changed practice and whether any further changes in practice should be considered.

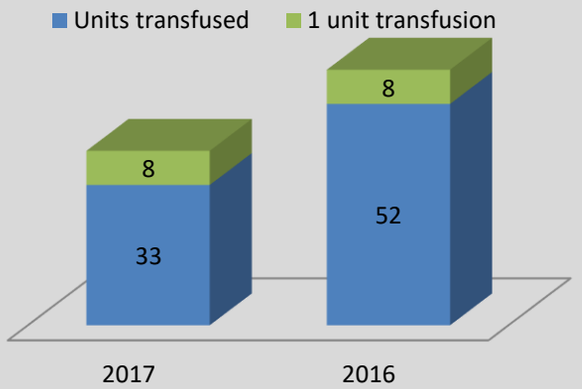
SASH policy Jan 2017; Antenatal anaemia



Audit design

We assessed 2 months in 2016 before, and in 2017 after policy publication. We looked at the number of transfusions, whether iron studies were requested and if PO/IV iron was provided. The information was obtained from discharge summaries and apex blood results. Only those patients receiving blood in pregnancy and puerperium were assessed. This includes massive blood loss events which will influence the data.

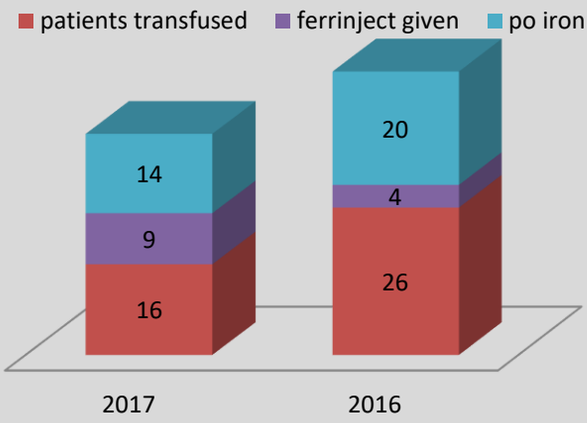
Transfusions



Iron studies

In 2016 19% and in 2017 31% of patients had Ferritin and 1 patient had iron studies checked during the whole of pregnancy prior to transfusion.

Iron replacement



MCV is higher in pregnancy. Should we trigger at <96? It is difficult to assess MCV as a marker of IDA in this data as so few patients had their ferritin/iron checked.

All transfused patients had an MCV <96 in 2016 & 17.
Average trigger Hb in 2017 was 75.3g/L
Average trigger MCV in 2017 was 83.7
Average trigger Hb in 2016 was 83.5g/L,
Average trigger MCV in 2016 was 81.2

IV iron was given to 4 people in 2016, and 9 in 2017.
The average Hb trigger for iv iron was 72 in both years, and the MVC was 91 in 2016, 84 in 2017.
PO iron was given to almost all patients in both years.

Conclusions. 1. Adherence to policy for checking iron studies is poor. **2.** IV iron is being given more, but may be under-represented in this audit which only looks at the admission for transfusion. **3.** PO iron is given well. **4.** An MCV of <85 would be suggested as a trigger for IV iron. **5.** This data includes massive blood loss where the emphasis is not on iron replacement. **6.** Transfusions are falling, but 1 unit transfusion needs to increase.

Plans for the coming year?

1. Audit adherence to oral iron through pregnancy.
2. ?Midwives to check ferritin/iron at 28/40.
3. Reassess protocol and emphasise IV iron as OP.
4. Trial of iron/ferritin for all transfusion requests.
5. ?Business case for pre-op anaemia clinic.
6. Consider MCV <85 and HB<70 as transfusion triggers?

Special thanks to Elizabeth Tatam, Karen Allnutt, Rashmi Rook, and Sharmila Sivarajam