SOUTHAMPTON UNIVERSITY HOSPITALS NHS TRUST

APPROVED **GUIDELINES**

PROFORMA

Title of document:		Women who decline blood transfusion – Management of: Guidelines	
Author: (Name & Position)		Karen Brackley Consultant	
Keywords		Post partum haemorrhage; primary and secondary obstetric haemorrhage; bleeding after delivery; syntocinon; ergometrine; misoprostol; hemabate; B-Lynch Brace suture; hysterectomy	
Description		Guideline for the management of women who decline blood including use of different medical and surgical techniques to prevent and stop bleeding from the genital tract following delivery	
Final Validation Committee		Directorate Clinical Governance Steering Group	
Date agreed: (*can be manually added when document validated*)	Sep-02	**Date sent to Policy Administrator:** (*can be manually added when document validated*)	Sep-02
Accountable Officer: (Name & Position)		David Howe Clinical Services Director	
Responsible Officer: (Name & Position)		Matthew Coleman Consultant	
Directorates who use the document:		Obstetrics & Gynaecology	
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Details of most recent review:

Recombinant factor VIIa replaces Beriplex.	Dec 05 (KB)
Use of cell salvage techniques to be discussed.	Dec 05 (KB)
Details of consultant referral	Feb 06 (MAC for CGSG)

Signature of Chairman of Validation Committee: Matthew Coleman
Print Name: Matthew Coleman
Post Held: Chairman Clinical Governance Steering Group

MANAGEMENT OF WOMEN WHO REFUSE BLOOD TRANSFUSION

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Massive obstetric haemorrhage is often unpredictable and can threaten life in a short time. Very few women will refuse transfusion in these circumstances but if it is thought likely that they may do so the management of massive haemorrhage should be considered in advance.

1. BOOKING

•Women should be asked their religion at booking and Jehovah's Witnesses or others likely to refuse transfusion should be asked if they would be willing to receive blood and their answer noted.

• They should be given all the relevant information about the risks of refusing transfusion in a non-confrontational manner. They should be advised that if massive haemorrhage occurs they are at greater risk of requiring hysterectomy or dying.

• If they decide against receiving blood under any circumstances they should be advised to book for delivery at the Princess Anne Hospital.

•They should be asked to complete an advance directive form regarding the refusal of blood/blood products, which should be filed in the notes.

2. ANTENATAL CARE

•The woman's blood group and antibodies should be checked in the usual way and haemoglobin checked regularly.

• Oral iron supplements should be given throughout pregnancy to maximise iron stores.

• If the low haemoglobin is not responding to oral iron therapy, IV iron sucrose (Venofer) should be considered.

• For elective surgery it may be possible to store blood in advance for autotransfusion, which may be acceptable to some women. If complicated surgery is anticipated eg anterior placenta praevia with previous Caesarean section, consideration of cell salvage techniques should be discussed with the woman involving anaesthetists and haematologists.

• If any complications occur antenatally the consultant should be informed.

3. LABOUR

•The senior registrar or consultant on duty should be made aware when a woman who refuses blood transfusion is admitted in labour.

• A venflon should be inserted and blood taken for FBC.

• The labour should be managed routinely by experienced midwives. The third stage of labour should be actively managed with 10u IM Syntocinon, early cord clamping and controlled cord traction after placental separation.

- The woman should not be left alone for at least an hour after delivery. Misoprostol or an IV Syntocinon infusion should be considered after delivery to minimise blood loss (50u in 500mls Normal saline at 50mls/hr).
- If Caesarean section is necessary this should be performed by an SPR 4-5 or Consultant and the anaesthetic also given by the most senior person available.
- Following discharge the mother should be warned to report promptly if she has concerns about heavy bleeding.

4. IF HAEMORRHAGE OCCURS

4.1 **Avoid delay.** The most important aspect of management is to avoid delay in treatment so rapid decision-making is necessary. If unusual bleeding occurs antenatally, in labour or the puerperium the Consultant obstetrician should be informed and the standard management started promptly.

4.2 **Low threshold.** The threshold for intervention should be lower than in other patients. Extra vigilance should be exercised to quantify any abnormal bleeding and to detect complications such as clotting abnormalities promptly. Slow but persistent blood loss requires action.

4.3 **Informing seniors.** The Consultant anaesthetist should be informed as soon as abnormal bleeding is apparent and the Consultant haematologist notified for advice.

4.4 **Intravenous fluids.** Crystalloid and artificial plasma expanders such as Gelofusine should be used.

4.5 **Other drugs.** In cases of severe bleeding the following drugs should be considered **after discussion with the Consultant haematologist:**

- Vitamin K 10mg should be given slowly IV.
- Desmopressin 0.3 micrograms/kg IV or subcutaneously (over 30 minutes).
- Fibrinolytic inhibitors such as aprotinin (Trasylol) 1 000 000 U. It is preferable to give a test dose of 1ml (10 000U) at least 10 minutes prior to the remainder of the dose due to the risk of anaphylactic reaction.
- IV tranexamic acid (Cyclokapron) 1g tds daily, IV or orally
- Recombinant factor VIIa 90 micrograms/kg as a bolus repeated after 3-4 hours. Tranexamic acid is useful in addition to stabilise the clot.

4.6 **The woman** should be kept fully informed about what is happening. The information should be given in a professional way by someone she knows and trusts. If standard treatment is not controlling the bleeding she should be advised that blood transfusion is strongly recommended. Any patient is entitled to change her mind about a previously agreed treatment plan. You should be satisfied that she is not subjected to pressure from others, and it may be appropriate to ask those accompanying her to leave the room for a while so that she can be asked if she is making the decision of her own free will.

4.7 Refusal maintained. If she maintains her refusal to accept blood or blood products her wishes should be respected. The legal position is that any adult (over 18) who has the necessary mental capacity to do so is entitled to refuse treatment even if it is likely that refusal may result in their death. No other person is legally able to consent to treatment for that adult or to refuse treatment on that person's behalf.

Staff should maintain a professional attitude and must not lose the trust of the patient as further decisions e.g. hysterectomy may need to be made.

4.8 Surgical techniques (see postpartum haemorrhage guidelines). Hysterectomy is usually a last resort in treatment of obstetric haemorrhage but with these women delay may increase the risk. The woman's life may be saved by timely hysterectomy, although even this may not guarantee success. Subtotal hysterectomy can be just as

effective as total hysterectomy, and may be quicker and safer. The timing of hysterectomy is a decision for the consultant present in theatre.

4.9 Further management. If the woman survives the acute episode and is transferred to ITU, the management should include erythropoietin (one bolus 40 000 U), parenteral iron therapy using IV iron sucrose (Venofer) 200mg x 3 per week and adequate protein for haemoglobin synthesis. Vitamin B12 and folic acid supplements should be given. Hyperbaric oxygen therapy is an option in life-threatening anaemia.

If the woman dies in spite of all efforts the relatives need support like any other bereaved family. Such a death is very distressing for the staff involved who may also need support.

4.10 Other enquiries: Hospital Information Services for Jehovah's Witnesses Tel: 020 8906 2211 (24 hour); e-mail his@wtbts.org.uk
Local Hospital Liason Committee officers: John Fry (Chairman) 02380 434577
Graham Bannister 02380 773073

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