

LoPAG

Platelet Champions Newsletter

Edition 6 – Summer 2016



Dear Platelet Champion,

Welcome to the 6th LoPAG newsletter. This edition is all about LoPAG Top Tip Number 6 – *Consider using D positive platelets in adult males who are bleeding* and we have included some useful information on page 2 to support this. Please do share with us if you manage to make this change at your hospital and what impact it makes in your platelet management.

I am very happy to announce the date of our next Platelet Champions Day on **November Wednesday 23rd**. This will be held at NHSBT in Tooting and is free for Platelet Champions. We will be sending out the agenda and booking form very soon so please book early to avoid disappointment.

Finally I would like to announce a new Chair to LoPAG. After 5 years I am stepping down and handing over to Sarah Clark, Platelet Coordinator at the Royal Free NHS Foundation Trust. As NHSBT continue to highlight the issues with keeping up with platelet demand, Sarah will continue the work of LoPAG in assisting Platelet Champions in their platelet management within their own organisations.

Rachel Moss – Chair of LoPAG

Apr 2016 - Platelet Issues

National Platelet Issues - 21008

Regional Platelet Issues - 5316

May 2016 - Platelet Issues

National Platelet Issues - 21955

Regional Platelet Issues - 5779

Jun 2016 - Platelet Issues

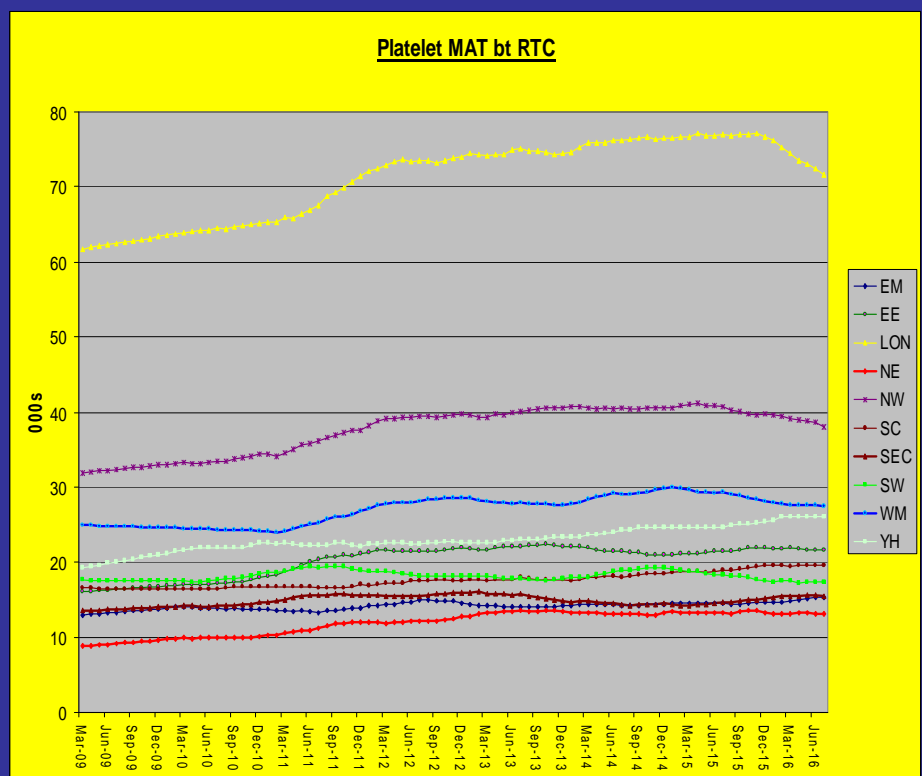
National Platelet Issues - 21577

Regional Platelet Issues - 5676

Jul 2016 - Platelet Issues

National Platelet Issues - 21758

Regional Platelet Issues - 5630



National Platelet Resources available at: <http://hospital.blood.co.uk/>

LoPAG Top Tips to reduce platelet usage and wastage NUMBER 6

Consider using D positive platelets in adult males who are bleeding.

Give D negative platelets for D negative patients where anti-D would be a problem but in adult males who are actively bleeding, use D positive platelets if you have them available.

Use of D positive Platelets in an D negative male – A Case Study.

With the demand for platelets ever increasing, it is important that hospitals look at ways to improve the efficiency of their use.

Top Ten Tip number 6 from the London Platelet Action Group (LOPAG) is to '**Consider using D positive platelets in male patients who are bleeding**'. Here is a case study showing this top ten tip put into action.

In March 2016 a gentleman that had been involved in a road traffic collision was brought to the emergency department as a Major Trauma Code Red. The patient was grouped as being A D negative and was quickly switched on to group specific components.

At the same time in the hospital, there was an obstetric haemorrhage and the lady was also D negative.

These two cases happening simultaneously meant that a decision was made to give D positive platelets to the male patient and conserve the D negative for the female patient.

The male patient received a total of seven bags of D positive platelets. He incremented appropriately and was **NOT** given a dose of prophylactic anti-D. No further follow up of this patient has been undertaken to check for D sensitisation.

The decision to give D positive platelets was made by the haematology team and was based on the likelihood that the patient would present again and be transfused with D mismatched components and also that the risk of D sensitisation was small.

No reactions were noted in the patient at the time of the transfusion or during the admission period.

Kelly Nwankiti – Trust Patient Blood Manager, Kings College Hospital

Low incidence of anti-D alloimmunisation following D+ platelet transfusion: The Anti-D Alloimmunisation after D-incompatible Platelet Transfusions (ADAPT) study.

Rh antigens are not expressed on the platelet (PLT) membrane.

Platelet concentrates are labelled for transfusion by the D status of the donor because of the presence of small quantities of D positive red blood cells (RBC).

The Biomedical Excellence for Safer Transfusion (BEST) Collaborative designed an international, retrospective study (ADAPT) to collect data from D negative patients who received D positive PLT transfusions to determine the frequency of D alloimmunisation.

11 centres from 5 countries contributed data.

RBC content of PLTs 0.036ml (whole blood) and 0.00043ml (apheresis).

Data analysis suggest D alloimmunisation following PLT transfusion maybe as low as 7%.

Due to this risk current guidelines recommend that D- recipients, particularly women of childbearing potential, should receive D- PLTs.

Frequency of primary D alloimmunisation in the study was 7/485 (1.44%).

Your Case Studies

Next Issue (Spring 2017) – “Top Tip Number 7 – Introduce the National Blood Transfusion Committee Indication Codes for platelets so that any requests outside the accepted criteria can be reviewed if appropriate.”

This could be done to empower the BMS staff or used as a way of deciding when to get the haematology medical staff to intervene.

Has this process been successfully implemented in your hospital? If so get in touch and we'll include your case study in the next edition of the newsletter.

Please send feedback and comments to Clare.Denison@nhsbt.nhs.uk