9.3: Red cell transfusion in pregnancy

Clinical audits show that many transfusions in pregnancy, especially in the postpartum period, are inappropriate and could be prevented by better antenatal monitoring and the targeted use of iron supplements. Transfusion exposes women to the risk of sensitisation to red cell antigens and haemolytic disease of the fetus and newborn (HDFN) in subsequent pregnancies. In the absence of major haemorrhage, the decision to transfuse should be made after careful clinical assessment rather than on the basis of a specific Hb concentration. Clinically stable, healthy women with Hb >70 or 80 g/L can usually be managed with oral or parenteral iron. Transfusion should be reserved for women with continued bleeding (or at risk of further significant haemorrhage), severe symptoms that need immediate correction or evidence of cardiac decompensation.

Obstetric units should have agreed local guidelines for red cell transfusion in women who are not actively bleeding. Cytomegalovirus (CMV) seronegative red cells should be provided, where possible, for pregnant women. In an emergency, such as major haemorrhage, standard leucocyte-depleted components should be given to avoid delay.