

# NHMRC/ANZSBT CLINICAL PRACTICE GUIDELINES 2001

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## RED CELLS:

Hb should not be the sole deciding factor. Consider patient factors, signs/symptoms of hypoxia, ongoing blood loss etc.

**Hb <70g/L:** lower Hb may be acceptable if asymptomatic, or specific therapy available.

**Hb 70-100g/L:** to relieve clinical symptoms or signs of impaired oxygen transport, or during surgery with major blood loss.

**Hb >80g/L:** may be appropriate to control anaemia-related symptoms in patients on chronic transfusion regime or during marrow suppressive therapy.

**Hb >100g/L:** not likely to be appropriate.

## FRESH FROZEN PLASMA:

**Likely to be appropriate: Single factor deficiencies:** use specific factors where available.

**Warfarin effect:** in the presence of life-threatening bleeding.

**Acute DIC:** In the presence of bleeding and abnormal coagulation. (Not indicated for chronic DIC).

**TTP:** accepted treatment.

**Liver disease, or following massive transfusion or cardiac bypass:** in presence of bleeding and abnormal coagulation.

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## PLATELETS:

Likely to be appropriate as prophylaxis:

In absence of risk factors if count  $< 10 \times 10^9/L$ .

In the presence of risk factors

(eg fever, antibiotics, systemic haemostatic failure), if count  $< 20 \times 10^9/L$ .

For most surgery/invasive procedures to maintain count  $> 50 \times 10^9/L$ . For surgery with high risk of bleeding (eg. ocular or neurosurgery) to maintain count  $> 100 \times 10^9/L$ . For platelet function disorders (inherited or acquired, and where platelet count is not a reliable indicator), depending on features.

Likely to be appropriate as therapy:

**Bleeding:** when thrombocytopenia is considered a major contributory factor.

**Massive haemorrhage:** when thrombocytopenia eg  $< 50 \times 10^9/L$  or functional abnormality is contributing (or  $< 100 \times 10^9/L$  with diffuse microvascular bleeding).

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FOR FURTHER INFORMATION PLEASE REFER TO THE WEBSITE: [www.health.vic.gov.au/best](http://www.health.vic.gov.au/best)