

Red Cells

Hb	Consideration
<70g/L	lower threshold may be appropriate in pt without signs + symptoms
70-100g/L	appropriate in major blood loss, or with signs + symptoms of impaired O ₂ transport
>80g/L	to control anaemia related symptoms in pt. with chronic transfusions, or during marrow suppressive therapy
>100g/L	unlikely to require transfusion

Hb should not be sole deciding factor.
Decision to transfuse based on clinical assessment

Fresh Frozen Plasma—appropriate use

- Warfarin reversal—life threatening bleeding. Use in addition to Vit.K.
- INR >1.5 with ongoing bleeding
- If bleeding occurs with abnormal coagulation due to:
 - acute DIC (not chronic)
 - massive transfusion
 - cardiac bypass
 - liver disease
- Single factor deficiencies—if specific factor unavailable
- Coagulation inhibitor deficiencies—high risk procedures (use specific factors if available)
- Thrombotic Thrombocytopenic Purpura

Platelets—to prevent bleeding

- Count <10x10⁹/L with no risk factors
- Count <20x10⁹/L with risk factors (eg. fever, antibiotics, systemic haemostatic failure)
- Count <50x10⁹/L most surgery and invasive procedures
- Count <100x10⁹/L surgery with high risk bleeding complications (ocular or neurosurgery)
- Platelet function disorders—inherited or acquired, dependant on clinical setting (platelet count is not a reliable indicator)

Platelets—to control bleeding

- Bleeding—where thrombocytopenia is a major contributor
- Massive Haemorrhage—thrombocytopenia and/or functional abnormalities. Platelet count <50x10⁹/L or <100x10⁹/L if diffuse microvascular bleeding

Cryoprecipitate

Fibrinogen deficiency—with clinical bleeding, invasive procedure, DIC or trauma

NHMRC Clinical Practice Guidelines
Appropriate use of Blood Components 2001
www.nhmrc.gov.au

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