2022 Annual SHOT Report – Supplementary information

Chapter 24: Haemoglobin Disorders

Additional case studies not included in the main 2022 Annual SHOT Report.

Haemolytic transfusion reactions (HTR)

Case 24.9: HTR following transfusion abroad

A teenager with SCD presented to a hospital for the first time unwell with symptoms including fever, vomiting, jaundice, and dark urine. There was evidence of haemolysis with a Hb of 50g/L and a positive antibody screen. The patient was new to the UK and had recently received a transfusion abroad prior to travelling.

IBCT-specific requirements not met (IBCT-SRNM)

Case 24.10: Laboratory not informed that transfusion was for a patient with SCD

A female in her 50s with SCD presented with abdominal pain and was generally unwell. The medical team requested three units of red cells but did not inform the laboratory that the patient had SCD. It was not clear if the haematology team were consulted from the report. The patient received blood which was not Rh- and Kell-matched and was not HbS-negative.

Case 24.11: IBCT-SRNM in a patient with SCD on multiple occasions

A man in his 20s with SCD received a blood transfusion. The laboratory team noticed after the blood had been given that the request form stated a diagnosis of SCD. On looking back at the transfusion record it was apparent that the laboratory had issued blood for this patient on at least two prior occasions without knowledge of his diagnosis and therefore specific requirements were not given for each episode.

Case 24.12: System flag in place but blood components that did not meet the specific requirements given

An adult female with non-transfusion dependent thalassaemia required a one-off transfusion. The laboratory had a flag on the system for specific requirements but incorrectly administered c-positive units. No subsequent antibody was identified.

IBCT-wrong component transfused (IBCT-WCT)

Case 24.13: ABO-incompatible transfusion in SCD resulting in major morbidity

A man in his 40s with SCD attended for elective red cell exchange. He was inadvertently given the wrong red cell unit intended for another patient. The SCD patient was group O and received group B red cells. The patient developed loin pain, rigors and hypotension and was admitted for close observation. The patient improved and recovered with supportive measures.

Delayed transfusions

Case 24.14: Delay in top-up transfusion in SCD resulting in clinical deterioration and need for red cell exchange

A young female with SCD was reviewed and a plan made for two units of red cells; it was handed over to the nursing team to transfuse as soon as the units became available. The following morning the patient had deteriorated at which point it became apparent the red cells had not been given. Due to the clinical deterioration an urgent red cell exchange was arranged. The nursing staff reported that it was unclear if the transfusion was to be given.

Case 24.15: Delay in top-up transfusion in SCD resulting in clinical deterioration and need for red cell exchange

A patient in her 20s with SCD was diagnosed with acute chest syndrome and a plan made for three units of red cells. The nursing team did not give the transfusions overnight due to pyrexia. Overnight there was a deterioration in the patient resulting in the need for emergency red cell exchange.