Anti-D Immunoglobulin (Ig) Administration in Pregnancy- an aide memoire

Key points to note:

- Women who are confirmed to have immune (allo) anti-D do not need (or should not receive) anti-D Ig
- Where the results of the cell free fetal DNA (cffDNA) screening test are available and show that the fetus/baby is D-negative, anti-D Ig does not need to be given
- Confirm that the cffDNA result relates to the current pregnancy
- Person administering anti-D Ig should confirm the woman's identity, discuss risk/benefits, gain informed consent and record in patient's notes. Confirm product dose and expiry date
- Following potentially sensitising events (*PSE- see appendix 1)*, anti-D Ig should be administered as soon as possible and always within 72 hours of the event. If, exceptionally, this deadline has not been met some protection may be offered if anti-D Ig is given up to 10 days after the sensitising event
- Each new sensitising event should be managed with a dose of anti-D Ig independent of previous or subsequent planned doses (including RAADP)
- In the event of continual uterine bleeding which is clinically judged to represent the same sensitising event, with no features suggestive of a new presentation or a significant change in pattern or severity of bleeding, a minimum dose of 500IU anti-D Ig should be given at 6 weekly intervals. Feto-maternal (FMH) screening should be performed every 2 weeks from 20 weeks onwards
- Appropriate tests for FMH should be carried out for all D-negative, pregnant women who have had a PSE after 20 weeks of gestation and additional dose(s) of anti-D Ig should be administered as indicated
- Routine Antenatal Anti-D Ig Prophylaxis (RAADP) is a separate entity for unidentified events through to delivery, and should be always be given at the appropriate time in the second trimester, even if the woman has already received one or more doses of anti-D Ig for PSE

<table>
<tr><th colspan="2">Potentially sensitising events (PSEs) during pregnancy (see Appendix 1 on next page)</th></tr>
<tr><td colspan="2">Gestation LESS than 12 weeks</td></tr>
<tr><td>All surgically managed abortions, ectopic/molar pregnancies and miscarriages</td><td rowspan="4">Administer at least 500IU anti-D Ig within 72 hours of event.
Confirm product / dose / expiry and patient ID pre-administration</td></tr>
<tr><td>Medical abortions beyond 10 weeks</td></tr>
<tr><td>Gestation 12 to 20 weeks</td></tr>
<tr><td>For any potentially sensitising event (PSE) including medical and surgical miscarriages, abortions and ectopic/molar pregnancies

For continuous uterine bleeding (see key points above)</td></tr>
<tr><td colspan="2">Gestation 20 weeks to term</td></tr>
<tr><td>For any potentially sensitising event (PSE)
(Irrespective of whether RAADP has been, or is planned, to be given imminently)</td><td>Request a test for FMH (e.g., Kleihauer test) and immediately administer at least 500IU anti-D Ig within 72 hours of event.</td></tr>
<tr><td>If the test for FMH (e.g., Kleihauer Test) indicates that further anti-D Ig is required</td><td>Administer additional anti-D Ig following discussion with laboratory, adhere to follow up FMH testing requested by laboratory to ensure all fetal cells are cleared</td></tr>
</table>

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Routine Antenatal Anti-D Prophylaxis (RAADP)	
For Routine Antenatal Anti-D Prophylaxis (**Irrespective** of whether anti-D Ig already given for PSE)	Take a blood sample to confirm group and antibody screen – do not wait for results before administering anti-D Ig
	Administer **1500IU** anti-D Ig at **28 – 30** weeks
	OR
	Administer at least **500IU** anti-D Ig at **28** weeks and then administer at least **500IU** anti-D Ig at **34** weeks
At delivery (or intrauterine death (IUD) >20 weeks	
If the baby's group is confirmed as D-positive OR If cord samples are not available following IUD	Request a test for FMH (e.g., Kleihauer test) Administer at least **500IU** anti-D Ig within 72 hours of delivery
If the test for FMH (e.g. Kleihauer Test) indicates that further anti-D is required	Administer additional anti-D Ig following discussion with laboratory, adhere to follow up FMH testing requested by laboratory to ensure all fetal cells are cleared

Safe administration and documentation practice:

1. Confirm patient ID with the prescription/product label
2. Confirm cffDNA result for current pregnancy
3. Confirm the anti-D Ig dose is correct
4. Confirm the anti-D Ig has not expired
5. Take G&S prior to administration but do not wait for results
6. Record anti-D Ig batch number & administration date in clinical notes

Appendix 1- Potentially sensitising events in pregnancy (From the 'BCSH guideline for the use of anti-D immunoglobulin for the prevention of haemolytic disease of the fetus and new born 2014 ')

Amniocentesis, chorionic villus biopsy and cordocentesis	*Intrauterine death and stillbirth*
Antepartum haemorrhage/Uterine (PV) bleeding in pregnancy	*In-utero therapeutic interventions (transfusion, surgery, insertion of shunts, laser)*
External cephalic version	*Miscarriage, threatened miscarriage*
Abdominal trauma (sharp/blunt, open/closed)	*Therapeutic termination of pregnancy*
Ectopic pregnancy	*Delivery – normal, instrumental or Caesarean section*
Evacuation of molar pregnancy	*Intra-operative cell salvage*

This aide-memoire was updated in September 2021 and is based on BSH Guidelines titled 'BCSH guideline for the use of anti-D immunoglobulin for the prevention of haemolytic disease of the fetus and newborn 2014'.NICE guidance documents can be found at: NG 126 (https://www.nice.org.uk/guidance/ng126/chapter/Recommendations#anti-d-rhesus-prophylaxis) and NG 140 (https://www.nice.org.uk/guidance/ng140/chapter/Recommendations#anti-d-prophylaxis). Please note that this has been reviewed and approved by the BSH Transfusion Taskforce and is only for reference to help draft checklists locally. This aide memoire has been created in line with the planned update to the BSH guidelines.