Louise - a patient blood management case study

I'm James Isbister. I'm a clinical haematologist and I've had a career interest in the benefits and The risks of blood transfusion and more recently in the area of what we call patient blood management. Now I've become aware over the years that although transfusion frequently can be really life-saving in other circumstances we don't have really good evidence for efficacy of these

transfusions and we're questioning that we may be exposing patients more to a risk with little evidence for actual benefit. Now we're very fortunate that Louise here has agreed to come along and tell her story about an operation she had to go through and quite considerable therapy and it's an interesting story because Louise does come from a background of having some knowledge in the medical area transfusion area.

Louise's story is a really lovely story and in part because a lot of things went really well for her and and she's obviously had a good outcome.

It's a great story and it's really what should happen to everyone isn't it. My story began in 2009 where I went to give my usual blood donation and I'd been a blood donor for many years and at the pre-donation testing they discovered that my haemoglobin was low. sSo they took a blood sample and told me to follow up with my gp. So a couple of weeks later the results came back and they showed my ferritin was at six. But my gp bless him, decided that he didn't think something

was wrong he thought something was wrong. So he sent me off for a colonoscopy. But at endoscopy and the biopsy later showed that I had a stage 3b rectal cancer. So it's quite a

serious, quite an advanced stage of cancer. So the next thing was to head off to - to meet a surgeon and it wasn't quite clear in the early stages, whether I would go straight off to surgery or have some chemotherapy radiation therapy first. But I knew what I wanted to happen first

and that was to have an iron infusion and the reason I wanted that was I'd been working in transfusion medicine research for a number of years and I was aware of the literature which has been published in the recent years. Which suggests that for those people who have transfusions blood transfusions their outcomes are poorer than those who don't in similar circumstances. So I reasoned that the best thing for me would be to increase my haemoglobin level and the quickest and most safe way to do that is an iron intravenous iron infusion. So I asked the surgeon I said I'd like to have an-an intravenous iron infusion and-and they arranged for me to have an iron infusion the next day. So within a week of seeing my I had an endoscopy I'd had a variety of diagnostic images and blood tests and I'd had an iron infusion. Interestingly enough two weeks later I met the oncologist. I felt better than I had for years and the iron if that wasn't lost on me that I would be diagnosed and despite the anxiety and all of that around my situation I felt fantastic. I got vitality and energy I hadn't had in years and I think in retrospect that feeling of wellness really helped me face what came after. Not just physically but emotionally, mentally I actually felt like I could deal with this situation I could beat the cancer because I felt I felt well for the first time. At that time at surgery my haemoglobin had risen as it had after the iron infusion up to 125 which is a pretty normal level. Following surgery it dropped down again to 107 just after

surgery. But within eight days postoperatively had it dropped right down to 83. Which is quite low but in consultation with the ward physician again, they were quite happy to let things ride. I had another iron infusion at that stage, but within a couple of weeks my haemoglobin was back up to normal again and I was able to avoid having a blood transfusion. But I was also fortunate in that I I

met with medical professionals, who were willing to engage in the conversation. Who didn't dismiss me out of hand as some crackpot who was demanding way out therapies.

You obviously handle it very well all the way through and but then on the other hand I think as you say you were fortunate with the medical profession. And I think that obviously your gp had a feeling, I mean it would be easy for your gp to have said oh look you know commonly people are fatigued yeah you're not actually severely anaemic and you know do nothing or to go away take a few iron pills. Clearly you had a had a feeling that things weren't quite right and then you see a surgeon that you could discuss with and was very open to a proper dialogue between you and

then that sort of went right through the rest of the system. So you really didn't come into significant conflict in the sense that you had to push hard for anything. No, not at all. It also worked through.

I particularly like your view on the general practitioner's role in the management of elective surgery in general. Well I think particularly when you're looking at elective surgery and a long-term relationship with the gp.

They'll often have on record the full blood counts of recent times and once you shift your gaze to thinking about preparation for the elective surgery, then clearly a focus on that haemoglobin and a focus on the iron studies is really important. I think that that role for gp's is really fundamental. I think by the time they get to their pre-anaesthetic and pre-admission consultations you've lost some really valuable time. Inevitably particularly for elective surgery, particularly for joint replacement surgery there will be some period of time in which you can be starting to address low haemoglobins and given that time you should make the best use of it you can. In the post-operative setting it's going to be very much the tolerance of anaemia and I just what I would be interested in in the post-operative setting is how do you dialogue with a patient. Well I think that you know medicine is all about the balance, isn't it. It's about the balance of risk and about the balance of risk and benefit essentially. And really that's the conversation you need to be having with patients. I think broadly in the community there is a sense that a transfusion is always good and I think that in fact we need to be talking to patients, about why you might not consider a transfusion and what actually are your options. And-and that you know while you're in this post-operative phase we have a bit of time that we could actually amend your iron status and thereby amend your haemoglobin without having to resort to a transfusion and without regretting the fact that intraoperatively you had didn't have a transfusion. That's actually a cause for celebration not for regret.

Particularly in Australia but in fact around the world anaesthetists are now much more involved early on in the preparation of patients and this is providing a platform for us to intervene. With interventions such as Louise had and I don't think we're doing it enough and I think this is a example of what we should be doing more. We're routinely having contact with the patient some days before surgery and there are lots of advantages to that. It gives us a chance to see the patient early. Do the tests that may identify if they're anaemic or even if they're not anaemic if they've got an iron deficiency and then put in place giving them iron which is the one where that's where most of the action is I suppose. And we've had some pretty interesting experiences similar to Louise with patients who even two days after an iron infusion come in smiling and saying wow this is the best I've felt for a long time.

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