INTRAUTERINE BLOOD TRANSFUSION: CARE OF THE WOMAN

PURPOSE
Intrauterine transfusion corrects anaemia produced by haemolysis of fetal red blood cells. Its aim is the birth of a healthy, term, non-anaemic baby.

INDICATIONS
- Significant fetal anaemia.

KEY POINTS
1. A specialist in Maternal Fetal Medicine must be available to determine the need for and perform the procedure.
2. The intra-vascular intra-uterine transfusion is performed in the Ultrasound Department.
3. The procedure is conducted under ultrasound guidance in Room 1.
4. The procedure takes approximately half to one hour to complete.
5. The fetus will be given a muscle relaxant to temporarily paralyse it prior to transfusion by giving IV or IM Vecuronium or similar agent.
6. It is performed as an Inpatient procedure.
7. Conscious sedation is used for the mother.
8. Blood Bank is to be contacted as soon as IUT has been scheduled. They will recommend when bloods are to be taken for group and cross match.
9. Blood compatibility can sometimes take days to organise.

Prior to the Procedure (Ward Inpatient Midwife)
1. Admit the women to antenatal ward as per usual antenatal admission
   - Maternal baseline observations, fetal heart rate and obstetric observations as per MR285.01.
2. Ensure the woman has fasted for 6 hours prior to the procedure.
3. Ensure the consent for IUT has been signed on the MR295 prior to the administration of the premedication. The Maternal Fetal Medicine Specialist will organise this prior to admission.
4. Check allergies.
5. Check whether betamethasone is required. Intrauterine transfusion is an invasive procedure associated with a small but significant chance of emergency Caesarean section.\textsuperscript{1} Therefore, corticosteroids for fetal maturation should be considered in preterm women undergoing intrauterine transfusion.\textsuperscript{2}


7. Measure and fit graduated compression stockings if not already in situ.

8. The Gold team resident shall site an IV cannula.

9. Ensure the premedication is given (if prescribed) 1 hour prior to procedure, liaise with Maternal Fetal Medicine (MFM) midwives.

10. Escort the woman (in a wheelchair) and her support person to the Ultrasound department.

11. Ensure the medication chart MR810.05 and observation chart MR 285.01 are with the maternal notes.

12. Perform Clinical handover from the ward midwife to MFM midwife.

13. MFM midwives shall notify LBS Co-ordinator, Theatre co-ordinator and SCN3 Co-ordinator of the time of the procedure and the gestation of the patient.

14. MFM midwives shall liaise with the blood bank re the availability of blood.

**During the procedure**

The Ultrasound PCA must be informed of time of transfusion and must remain in the department while the transfusion is in progress as the patient may require transfer to theatre for a NELUSCS.

**After the procedure (MFM Midwife / ward midwife)**

- The woman shall be transferred back to the ward on a trolley.
- Strict bed rest for 4 hours.
- Clinical handover by MFM midwife to ward midwife must occur.
- Blood Pressure, Pulse, Respirations and O2 Saturations and obstetric observations half hourly for 1 hour then routine antenatal observations.
- Vaginal loss and uterine activity half hourly for one hour, hourly for two hours, then four hourly for 24 hours or until discharged if less than 24 hours.

- Hourly Fetal Heart Rate until fetal movements return. Notify the MFM specialist if fetal movements have not returned within 4 hours of the fetal Vecuronium injection.

- From 28 weeks gestation CTG monitoring may be requested at the discretion of the MFM specialist.

- Take maternal blood for a Kleihauer test and administer Rh (-ve) immunoglobulin if requested. **Note:** Rhesus negative women with rhesus isoimmunisation will not require Anti D.

- Ensure a follow up scan has been arranged with MFM.

**REFERENCES (STANDARDS)**


**National Standards** – 1 Clinical Care is Guided by Current Best Practice

**Legislation** - Nil

**Related Policies** – Diagnostic Imaging

**Other related documents** – Nil

**RESPONSIBILITY**

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