



2010 SCABB Annual Meeting Ask the Experts

Q: Can the partial D antigen can be detected at any stage of Anti-D testing (IS, 37° or AHG) or just in the AHG phase?

A: *Monoclonal reagents can come down at an immediate spin. Yes/Partial D's, difficult to distinguish weak D's that don't produce allo anti D.*



Q: What happens when a partial D woman who receives RhIG after she delivers a D positive infant. Does the RhIG coat her cells and the infants, is it dependent on the type of partial D she is, if all the infant's cells are not coated what is the risk of HDN? What about an Rh Negative mom with an infant that is partial D positive – will RhIG always protect her?

A: *No studies to know if it protects her. No data.*



Q: The AABB Standards requires IS spin testing for transfusion patients and pregnant women and weak D testing for only blood donors and newborns for determining RhIG therapy for the mother. Many facilities perform weak D testing on all patients – could you describe the benefits and risks of this approach varying from AABB Standards?

A: *Can't think of any benefits – you do not want to do this test.*



Q: Is there any new industry discussion related to researchers coming closer to developing a hemoglobin based blood substitute that has a lesser effect in triggering heart attacks?

A: *After the last round and near miss industry really stepped back from this platform. Cell expansion would probably be better and we will not likely see this expand. Most likely at least 5 yrs. before we see any kind of impact.*



Q: How do you handle give away / incentive items for your deferred donors? What is your understanding of the regulatory impact of the practice?

A: *You have to offer the same incentive to all donors regardless of the item. There could also be state gaming law implications if you do hold drawings, specifically for big ticket items.*



Q: History of hepatitis continues to confuse us on donor eligibility. Is a donor with a well documented history of hepatitis secondary to a CMV or infectious mononucleosis infection eligible to donate?

A: *Only if before the age of 11. The FDA specifically states “viral” so that is the interpretation. For drug induced hepatitis, request letter from doctor to confirm that is not viral.*



Q: We have a FDA variance to transfuse blood from donors with hereditary hemochromatosis (HH). Some of our HH donors would like to regularly donate aphaeresis platelets along with concurrent RBC. Is this acceptable?

A: *It would depend on your specific FDA variance. You could also contact your CSO for additional guidance. . No medical reason why they could not donate this product. Check with manufacturer if Hct is extremely high. However, you owe the patient/donor the medical treatment of managing the Hct count.*



Q: We had a power failure to one of our plasma freezers. The freezer contained 60 units of AB cryo-poor plasma which we had purchased from Blood Centers across the US to support TPE on a Group AB TTP patient. The temperature in the freezer exceeded -18 degrees centigrade for approximately 1.5 hours minutes and the internal temperature never rose above -1 degrees centigrade. Is it within the authority of our Blood Bank Medical Director to deem the units acceptable for transfusion or do we need to obtain a variance from the FDA?

A: *No, FDA variance needed. This is a medical decision. A clear answer would be if you need the plasma now, may be grayer if you have other product available. Rare RBC outside storage temp but unit did not thaw is that okay – practice of medicine, medical decision.*



Q: Is it a requirement to maintain a temperature of 20 – 24 degrees C in our component production area?

A: *- BacT would play a role in regards to plts
- If sterile connection device is used there is a temp requirement.*



Q: We use Pall e-BDS for bacterial contamination testing of our apheresis platelets. When we get a e-BDS failure we quarantine all concurrent products for that donation. We then repeat the culture using the BactiAlert system. If the BactiAlert final culture is reported as no growth at 5 days would you feel safe using the concurrent products from that donation?

A: *Need to have this outlined in your SOP. No reason not to use the RBC unit if culture is negative. Medically ok, there could however be a legal implication if a reaction occurred with the unit. Could be an issue with FDA and testing into compliance with a repeat test. Required to follow up per AABB for all positive cultures regardless of the product.*



Q: There still seems to be debate on the safety of 16 year of blood donors, what are your thoughts on 16 year old donors and do you think there should be stricter guidelines for their blood donation?

A: *- Gulf Coast only allows WB donation. 122 lbs. guideline with parental consent
- Literature shows there are more reactions with younger donors (16 years old specifically) so you are taking risk without stricter guidelines.
- UBS based on total blood volume for donors 16-23.
- For 16-18 uses blood volume seeing a change in reactions at both ARC & UBS.
- Take their word on weight.*

Q: The Duke University data published in The Journal of Thoracic and Cardiovascular Surgery showed that plasma from female donors may actually be better not worse than plasma from men. How do you think we should address this issue specifically for centers who have gone to all male plasma products for transfusion?

A: *TRALI is poorly defined, not surprising that you will get some "gray" in these studies. Available additive solution will add another dimension to the TRALI discussion by diluting the risk of reaction by removing more plasma.*