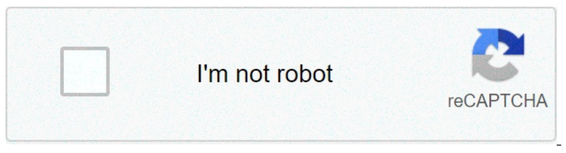

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Single donor platelet increase

How to prepare single donor platelets. What is single donor platelet. Single donor platelet count.

Platelet transfusions are contraindicated in patients with thrombotic thrombocytopenic purple (TTP), hemolytic urthemic system (HUs), or heparin-induced thrombocytopenia (HIT). While these conditions may have marked thrombocytopenia, they are usually prostrombotic and platelet transfusion may have the fire if the fire became a prophylaxis in the absence of significant bleeding. Platelet transfusions are controversial in patients with transfusion purpura, since the specific antibodies of platelets against high frequency plateautary antagens are part of the pathophysiology of this potentially fatal distance. IVIG is typically a first-line therapy and immediate consultation with hematologist and / or its transfusion medium of institutions is highly recommended. Platelet transfusions in patients with autoimmune platelet destruction, such as ITP, should not be transfused in bleeding absence because the transfused platelets will be quickly removed in a similar way to the patient platelets without benefit Clinical. If a transfusion reaction is suspected, the transfusion must be interrupted, the patient evaluated and stabilized, the notified blood bank, and a transfusion reaction investigation The initiated. The massive or rapid transfusion can lead to arrhythmias, hypothermia, hypercalemia, hypocalcemia, dyspnea and / or cardiac insufficiency. Platelet products have an increased risk of significant bacterial contamination / bacterial sepsis in comparison with other blood products because platelets should be stored at room temperature, since they quickly lose functions when Refrigerated. It is believed that the risk of platelet transfusion sepsis is at least 1: 75,000 and the risk of fatal passive platelet transfusion reactions is at least 1: 500,000. Bacterial contamination is most commonly caused by gram-positive skin flora, such as Staphylococcus spp, but the processes can be due to a contamination of gram-positive organism or gram- negative. Gram-negative bodies are generally associated with more severe reactions, but broad spectrum antibiotics should be initiated until the causative organism is identified. Due to short platelet life (5 days of collection), it is not uncommon that blood banks experience scarcity of platelets that can delay the transfusion for those who have urgent need of transfusion . If the identical platelets are not available, donor platelets that are compatible with plasma abo can be used. This may occasionally result in suboptimal responses, since platelets have a variable amount of ABO antagonals, but will not cause clinically significant problems. In large children and adults, non-platelet incompatible ABO may be issued only with minimum risk of hemonomic, unless large doses of unfounded platelets are transfused. If platelets that are identical or plasma compatible donors are available, the efforts to reduce the volume reduction or wash the platelets can be considered for neonates if platelets are not required with urgency. The wash and volume reduction requires significant delays in the transfusion and can change the quantity and quality of the plateau product. As all platelet products contain a small amount of RBCs, RH compatible platelets should be used if possible to avoid the formation of anti-D negative individuals. This is particularly important for fonds that are grateful or can become pregnant in the future due to the risk of fetus hemolytic disease and recipient due to anti D. The risk of anti-D formation, particularly in this population, can be minimized by providing Rhig within 72 hours of exposure. RHIG is often offered in intramuscular suspenders (IM) and (iv). The use of Rhig IV can be considered whether the required RHIG amount is large or the patient is increasing the risk of instant messaging injection injury, but it is not available in all institutions. A complete rhodan dose of RHIG will be sufficient to cover at least 5 adult doses of the whole set set Derived platelets or 7 doses of athletes. The dosage depends on the repetiÃ§Â £ Number of received HR-positive platelets doses and half-life Rhig and may need to be considered if it has been over 21 days since the dose Ã¤ltima Rhig and additional platelets RH should be transfused. Platelet transfusions may induce HLA antibody formation and rarely platelet-specific antibodies that can cause immunological refractoriness for future transfusions, particularly for patients requiring platelet transfusions. The CCI can help determine if the patient has immune refractoriness and his calculation is described in the pharmacological section. The reduction of leukocytes can help reduce HLA sensitization. Please see the monograph of reduced leukocytes blood products for more complete indications of reduced leukocyte products. Patients with specific HLA or platelet antibodies (HPA-1A) may benefit from corresponding HLA negative thigh platelet transfusions or HPA-1A, if available. Please see their respective monographs to get complete transfusion information. Patients with increased risk of TA-GVHD should receive irradiated plateauing products. For more information about radiating indicators to avoid TA-GVHD, consult the hemoderivados irradiated monograph. Patients who are seronegative CMV or whose CMV status is unknown and increase the risk of symptomatic CMV infection, should receive reduced CMV risk platelets. Please see the monographs of blood products from Soronegivative and Leukocytes of CMV for more information. All transfusions should be given through blood administration sets containing 170 to 260 mancron filters or micro-haunted filters from 20 to 40 to 40, unless the transfusion is given to a Reduction of bedside leukocytes. No other medicine or fluids beyond normal saline solution should be given simultaneously through the same line without consultation of the blood bank director. The patient must be monitored for signs of a transfusion reaction, including vital, during and transfusion. Infectious Hazards No Blessed Under HIV Transmission (~ 1: 2 Mill), HCV (~ 1: 1,5 Mill), HBV (1: 300K), HTLV, WNV, CMV, PARVOVÍRUS B19, DOENÃ Lyme, babesiosis, malaria, chaga disease of â €, VCJD. Consult the director Bank of Blood or Hematologist, if you have doubts about the special transfusion requirements. The platelet dose should be individualized. Several simple guidelines can be used to calculate the appropriate dose. A dose of 1 concentrated random donor platelets per 10 kg body weight may increase the platelet count in 5000 / UL in a patient not refractory. A donor platelet concentrate aleatÃ³rio Â © expected to increase platelet counts in 5000 to 10, 000 / ul in a 70 kg patient that does £ â © refratÃ¡rio. Generally, a set of 6 to 8 platelet concentrates or a single Afóse unit is enough to correct or prevent bleeding in a normal size adult, weighing until 90 kg. An Afóse product is equivalent to 6 to 8 platelet concentrates random donor and therefore should increase platelet count by 30,000 / ul to 40,000 / UL in a 70 kg patient. For pediatric patients, 5 ml / kg body weight of a random donor platelet concentrate should increase platelet count per 5000 / ul. A single platelet concentrate contained about 45 to 50 ml and should provide the needs of patients to 8 kg. If all platelet concentrate is not used for a particular patient, it is not practical to recover the rest of the unit. For children> 8 kg, a standard dose of 1 unit / 10 kg should be used. In the absence of increased platelet destruction, platelet transfusion Usually needs to be repeated every 3-5 days. If the increase in platelet destruction or consumption is present, daily administration may be required. Anemia is an important risk factor contributing to an increase in the risk of hemorrhage, particularly in thrombocytopic patients and patients with qualitative defects of the purchased platelets, such as Uremia. Uremia. Hematotics These patients in higher levels contribute to improving hemostasis and decreased bleeding. Hemodynamic studies have demonstrated that in higher hematotyps, red blood cells predominate in the central part of the bloodstream and push platelets peripheral where they are more readily available to interact with the endotth in lesion sites. For this reason, the laboratory recommends that if a patient is anthemic and thrombocytopenic, the red gluciles must be transfused before platelets. There are twenty years, Dr. Ness co-authorship An article describing the advantages of platelets of donor donors (SDP) on platelet pools derived from blood (WBDP), in an item in which he believed that the evidence strongly favored the Use of SDP (1). The potential advantages of SDP considered included the following: reduction of infectious complications; Reduction of transfusion reactions; Ease of leucodepletion; Reduction in transfusion frequency; Aloimunization prevention; Treatment of aloimmunized destinations; Enhancement of plateaut quality; Elimination of the need to join the WBDP in the transfusion service. At the time of this previous public, he had already been clear from the judgment of reducing alimmunization (trap study) in adult leukerman patients aimed at reducing aloimmunization by SDP It was possible. Randomized patients for SDP or WBDP had similar aloimmunization rates and platelet refractation (2); However, the other seven potential advantages listed above supported a recommendation for extensive or even exclusive use of SDP. The most substantial advantage of the SDP was the reduction of transfusion reactions of generated platelet (SPTR) of the bacterial contamination on platelets stored at room temperature. A 12-year study at Johns Hopkins demonstrated that the SPTR was markedly reduced after changing for the exclusive use of the SDP. As we move from a starting point at which 50% of platelets were WBDP at a point where 100% were SDP, a significant drop in SPTR was observed over time (3). Based on these data, the SDP is fundamental to reduce SPTR, we assume the initial step to use SDP exclusively. After this conversion to 100% of the SDP, we continue to track SPTR and only observe partial success, with reduction, but not eliminating significant reactions (4). In 2003, with the introduction of bacterial culture, these potentially lethal reactions were markedly reduced (5). Since then, the American Bangshaft Association (AABB) began to require blood culture, and most platelet transfusions in the US moved to the supply of bacterially cultivated SDP, since testing Confident bacterials â € â € and economy were not available for WBDP (6). More recently, it became recognized that the bacterial test reduced the SPTR rate by 60 - 70% thus continued to be space to further reduce these reactions. The United States Food and Drug Administration issued orientation to require an enhanced bacterial test later in platelet storage. The initial orientation was issued in 2016 and was finalized in 2019. Blank centers and hospitals could use larger platelet volumes in the culture system, with delayed sampling (7), the use of a detection device Bacterial Bacterial Based in Hospitals Subsequently in storage (8) or inactivation of pathogens (9) In addition, systems have become available for the WBDP pool in the center of blood and perform a single bacterial screening test Pool (10). With the implementation of these improved techniques, the most important initial advantage of SDP to reduce SPTR has become less relevant. However, it remains true that emerging viral infections would be less worrying about the WBDP opposition SDP. In fact, the inactivation technology of the It is only available for the SDP in the United States, making WBDP more susceptible to an emerging viral pathogen or even to a known transfusion transmitted the viral pathogen that was lost by the current tests of the current test. However, US blood centers have been able to respond quickly to new new Like the West Nile Virus, so that the strongest argument for the exclusive use of the SDP has become less persuasive. From the list of Possible SDP advantages, eliminating the need for platelet pool in the hospital was an important motivator for our change in Johns Hopkins for an exclusive SDP system. Nowadays, however, many countries have blood centers that are capable of providing Buffy coats WBDP clustered, thus eliminating the need for additional manipulation in the hospital transfusion service. In the USA, where Buffy coats are not yet licensed and available, blood centers can gather WBDP in evolving commercially available systems that allow the pool prepayment and reduce the 4 hours of pose-storage slack (10). Other possible advantages of SDP that were displayed in the previous list can still be voted, but remain proven. With respect to transfusion reactions, it is clear if the risk of acute pulmonary lesion related to the transfusion (Trali) is exacerbated by increasing the number of expositions of Donors in platelet pools or at the same time, by exposure to the largest amount of plasma of a SDP donor capable of provoking Trali. Likewise, the SDP prepared with the use of platelet-added solutions (PA) would seem less likely to cause major transfusion reactions, but convincing evidence of SDP superiority is not abundant (11). In fact, as regards outside the transfusions of the group, SDP is commonly suspended in the country and will have a lower plasmacy containment, which reduces the risk of hemorrholysis of anti-A / anti-B tits. For patients who require larger doses of platelets, it is likely that platelet pools with increases in the donor exposure can cause more reactions. However, in an attempt to avoid large doses unnecessary in children and neonates, most blood centers now divide the collections of thigh platelets in such a way that a patient requiring a larger dose of platelets supplied By SDP you can receive two or three products, each provided from a unique single donor. The indication for which the transfusion of the SDP still has important advantages is bleeding prophylaxis during therapy for hematolic malignancies. Aloimunization in these patients has been reduced, but not eliminated by the leukerigordo, so that a substantial subset requires platelets of cross antagonum or human leukocyte (HLA) that can only be obtained from the SDP. These chronically transfused patients are also most commonly observed to have additional transfusion reactions where SDP, particularly with the country, can reduce these annoyance reactions (12). As such, this population, which represents almost 50% of platelet recipients in the US, must be supported with SDP. Likewise, the combination of HLA / human plateau (HPA) is useful in cases of platelet or thrombocytopenia aloimmune neonatal (NAIT), and disabled donors of IgAs can prevent anaphylaxis in destined Disabled IgA rivers. For patients receiving platelets to trauma, surgical bleeding and other indications, the plateau source is less christ. Although there are in vitro evidence that the platelets collected by the Afése may have improved survival and less activity, enhanced activity in acute bleeding can be an indocumented advantage of WBDP (13). Concerning SDP, the WBDP has a content and comparable quality and efficiency. Most intensivists and surgeons would not worry about using WBDP for these patients, suggesting that, in the US, a movement for this for increased use of WBDP does not oppose. In most cases, the clinics that order platelets are likely to be aware that their patient is receiving SDP or WBDP. As US hospitals pay a protection for the SDP, this moves away from the exclusive use of the SDP would be useful for Transfusion costs in our complicated medical system. Another important consideration is the incompatibility in the platelet and demand supply. Although the patient blood management programs have substantially reduced red blood cell transfusions in the US, USA, Transfusions remained stables â € â € œ or grew. In turn, the main offering of Afóse's platelets comes from older committed donors that were difficult to replace younger donors (14). In addition, platelets suffering inactivity processes of the patgen produce reduced transfusion increments, requiring a greater number of Afghan platelet transfusions. As a result of these tensions in the offer of platelet donors, a consideration is now given to the provision of financial payments of encouragement to the donors of Afitis, while using the inactivation of platelet pathways collected from Donors paid to address the possibly higher infectious risks. Although struggling to meet platelet demand by SDP, many blood centers are reluctant to return to WBDP, and continue allowing platelet waste by discarding the plateau component of entire blood units. Based on these considerations, we believe that the main advantages that have boosted many hospitals to the exclusive use of SDP have become less significant and, by exception of oncological patients, moving to increased use of WBDP could relieve the Pressure in blood centers for SDP vest when alternatives exist. The solution can lie in the maintenance of a combined SDP inventory for patients with hematological malignancies and WBDP for other patients, and is expected to reduce the center of blood and hospital costs without compromising the patient care. Recognition Financing: None. Provenance and peer review: This article was commissioned by the Guest Editor (Pillar Resolves) for the series "Plate Transfusion" published in Anais of Blood. The article was not subjected to external peer review.Conflicts of interest: Both authors completed the uniform disclosure form Icmje (available at AOB-2020-EN-02). 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