

# National Transfusion Practice

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# The Anesthesia Quality Institute

**Vision:** To become the primary source for quality improvement in the clinical practice of anesthesiology

**Mission:** To maintain AQI's registries with case data as the primary resource for anesthesiologists looking to assess and improve patient care.

# Basic Principles

- The more you know, the better you do
- Quality management data
  - = research data
  - = business data
- Every patient encounter is a data point

# AQI Registries



Facility and Provider  
Information from >500 Practices

Case Data from  
> 30M Anesthetics

Clinical  
Outcomes  
From > 5M  
cases

AIMS Data  
from  
>1M Cases





# NACOR – University Hospital

- 40,982 cases
- 1,857 received a blood product intraop (4.53%)
  - 74% got RBC
  - 34% got plasma
  - 13% got platelets
  - 21% got cryoprecipitate



# NACOR – University Hospital

- 847 got RBC alone (mean 2 Units)
- 130 got plasma alone
- 128 got platelets alone
- 697 got a combination

# NACOR – University Hospital

- Max transfusion: 277 L
- More transfusion in older patients
- More in sicker patients
- More in longer cases
- More in inpatients

# Cases Receiving Transfusion

- CABG: 33%
- Heart valve: 44%
- Peripherheral vascular: 20%
- Liver transplant: 77%
- Hip replacement: 8%

# Variation in Transfusion

UHC Database

Common operations:

THR

colectomy

pancreas

Wide variability in transfusion rates

Quan, et al. Annals of Surgery, 2013

# Perioperative Mortality

In the Surgery Center:	0.003%
In the OR:	0.03%
In the hospital after major surgery:	3-4%
Overall:	100%

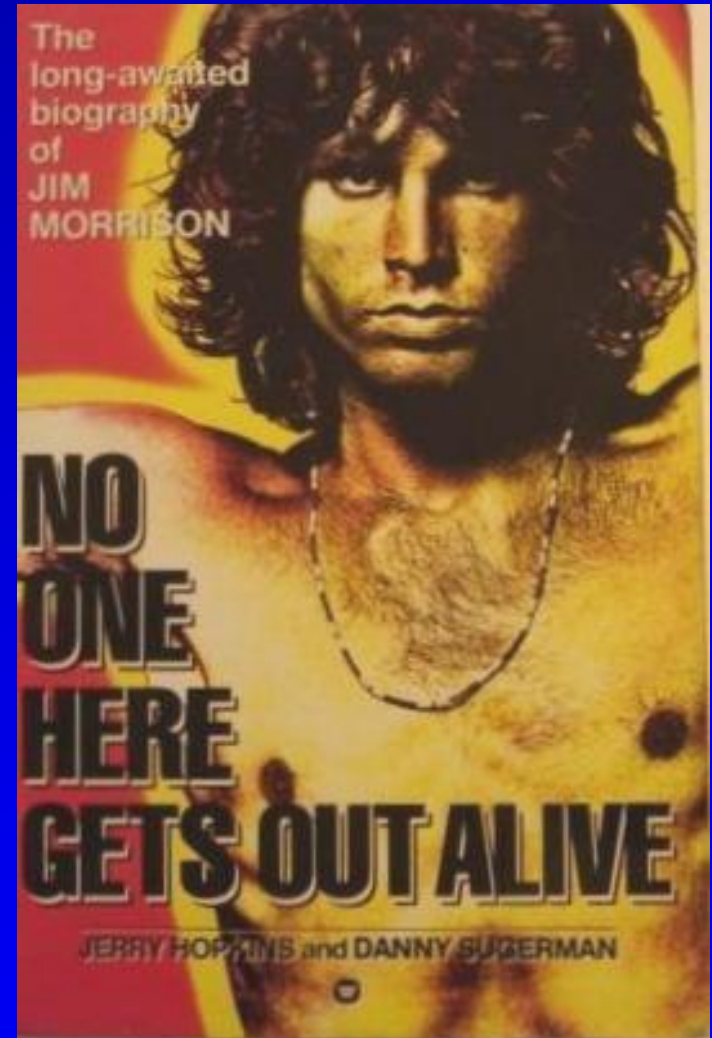
“In this world nothing  
can be said to be  
certain, except death  
and taxes”

--Benjamin Franklin



“No one here gets out  
alive”

--Jerry Hopkins and  
Danny Sugerman





# Death from Haemorrhage

- Rare, in general practice
- Usually associated with disasters
  - Audience Question: Laser Lead Removal?
- Better studied anecdotally than systematically

# AQI Registries

Anesthesia  
Quality Institute 

 CLOSED CLAIMS PROJECT and Its Registries

[www.asaclosedclaims.org](http://www.asaclosedclaims.org)

**Adverse Events  
& Near Misses**

[www.aqiairs.org](http://www.aqiairs.org)

# Hemorrhage and Legal Risk

PERIOPERATIVE MEDICINE

## Massive Hemorrhage

*A Report from the Anesthesia Closed Claims Project*

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# Data: The ASA Closed Claims Project

- Malpractice cases against anesthesiologists
- Reviewed by experts
- Blinded, de-identified abstraction
- 50% of cases, for 25 years
- About 10,000 cases per decade

# Malpractice from Bleeding

- 141 claims since 1995
- Cases are:
  - Younger
  - More emergent
  - More likely to suffer permanent harm
  - More likely to have substandard care
  - Twice as expensive (average \$450,000)

# Hemorrhage Claims...

- More likely to die (77%)
- More likely inappropriate care
- More likely to cost money
- Higher average payments
  
- Mostly related to UNEXPECTED bleeding

# Which Cases?

30%	Obstetrics
20%	Spine
15%	Minimally invasive or robotic
10%	Cardiac, vascular
5%	Major tumor
5%	Liver
2%	Trauma (none in past decade)



# Substandard Care

- Failure to identify a life-threatening condition
- Failure to promptly return to the OR
- Failure to obtain adequate IV access
- Failure to treat coagulopathy

## Table 7. Clinical Lessons

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Massive hemorrhage is a rare but serious cause of malpractice claims.

- High mortality
- High rate of payment to plaintiff
- Large payment size

Hemorrhage claims were most common in obstetric anesthesia and anesthesia for thoracic or lumbar spine surgery. Massive hemorrhage can also occur in low-risk procedures, *e.g.*, minimally invasive, laparoscopic, or robotic procedures.

Common features:

- Lack of timely diagnosis
- Lack of timely transfusion
- Lack of timely return to the operating room

Anesthesia care contributed to poor outcome in most claims.

Every surgical and obstetric facility should create and practice a plan to address unexpected massive hemorrhage.

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# Other Findings

70% Bleeding immediately recognized

15% Timely return to OR

15% Timely transfusion

# Obstetric Hemorrhage

- 50% have an obvious risk factor: known placenta accreta, coagulopathy, IUFD
- 50% from unexpected postpartum hemorrhage
- Bad outcomes occur in small hospitals with limited resources

# Minimally Invasive and Robotic

- Vascular injury
- Adjacent body compartment
- Diagnostic fixation
- Instability > fluids > pressors > coagulopathy > bad outcome
- Currently 86 reports of fatality with DaVinci surgical robot in FDA data

Contact Me!

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