2021 Annual SHOT Report – Supplementary information

Chapter 22: Paediatric Cases

Additional cases not included in the main 2021 Annual SHOT Report.

Paediatric overtransfusion cases

Case 22.10: Excessive transfusion related to use of wrong calculation

A young child with malignant disease had a Hb of 56g/L, weight 7.5kg and was transfused two adult units of red cells (approximately 67mL/kg), resulting in a Hb of 216g/L. The child required venesection. The doctor used a calculation designed for Hb g/dL but put in the Hb in g/L so the volume was a factor of 10 out.

Case 22.11: Absence of sense-check

A paediatric patient (<5 years of age) had an incorrect amount of blood prescribed; the patient was prescribed as if they were 46kg instead of actual weight of 13kg (and at the rate of 150mL/hour instead of 65mL/hour). The Hb was 122g/L pre transfusion, and Hb 184g/L post transfusion.

The final overtransfusion was not a prescribing error, but was a child with significant blood loss due to menorrhagia. Four units of red cells were transfused with no check of the Hb, no clinical reassessment between units, and no consideration of other management once the bleeding had stopped.