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Testing current practice is no mistake

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A response to these comments can be found
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Dear Editor,

In their recent paper entitled ‘Ten big mistakes in intensive care medicine’ [1], Vincent and colleagues wrote ‘We jump to prospective randomized clinical trials, before fully identifying the right patient population, and then struggle to interpret the results’ and cited this as one of the big mistakes, giving the TRISS trial as an example [2]. We obviously disagree.

The authors appear to have misunderstood the reasoning for our trial. The TRISS trial was done to test current practice for blood transfusion in patients with septic shock in Scandinavian ICUs [3]. In cohort studies, we have described current blood transfusion practice in septic shock as being frequent and driven mainly by haemoglobin levels independent of disease and shock severity and independent of time from shock debut [4–6]. Therefore, we included a

broad group of patients with septic shock in the TRISS trial. Haemoglobin of 7 and 9 g/dl were frequent pre-transfusion levels [5] and therefore chosen as triggers for blood transfusion in the TRISS trial.

In this context, the results of the TRISS trial are easily interpreted [2]. Using a transfusion trigger of 7 g/dl instead of 9 g/dl in a broad population of ICU patients with septic shock throughout their ICU stay seems to be safe and to reduce the rate of transfusion and the number of units transfused. As blood is an expensive and limited resource, we find this very useful for clinicians, guideline committee members and policymakers.

Conflicts of interest The authors have no relevant conflicts of interests.

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