The intra-operative use of blood products in neurosurgical operations

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Received: 24 April 2012 / Accepted: 26 April 2012 / Published online: 15 May 2012
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The occasional publication of the odd article may serve a purpose to the community of readers that may transpire not only from the immediate contents or the purported message conveyed by it but also by indirect inference allowed. That is certainly the case with the current paper.

The issue of how to handle blood products in neurosurgical procedures and, in a general manner, all aspects related to the best operating room (OR) performance are of extreme importance, and not only the technical aspects of the procedure itself. Positioning, monitoring, use of sterile techniques, circulation in the OR, intra-operative use of drugs akin to the surgical act, use of blood products, timing of the procedure, etc. are all aspects which need to be systematically assessed, audited and taught.

A surgeon, or a surgical team, who for a typified type of operation consistently takes considerably longer time than normal to conclude the surgical act, is also exposing the patient to an unnecessary risk. In the same manner, inordinate use of blood products is a stigma of poor quality. This can be translated both into an overuse of transfused units or of an inadequate and unjustified cross-matching of blood units. Blood is scarce, expensive, and too precious to be handled around in a frivolous manner.

For this reason, I think that the article serves the purpose of alerting us to this constant reality, and to the need for creating institutional policies based also on institutional evidence for the use of blood products, with a strong emphasis on the need to reduce the over-expenditure that many of our daily acts imply.

Whether this should be based on a percentage obtained after a certain number of operations of each type is only an incomplete way of looking at the problem.

The planning and anticipation of the average intra-operative need for blood products must take into account the type of operation, the type of patient, the type of anaesthesiologist and the type of surgeon. I do not believe this can be uniquely extrapolated from a percent figure out of a surgical series. It needs to be tempered by the individual appreciation of factors involved, which means that for each single case an honest estimation has to be reached by both the surgical and anaesthetic teams.

It is interesting to note the high number of units routinely cross-matched for neurosurgical procedures in this institution in the recent past. How recent was it and how did the data drawn from this study change the authors' practice?

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Conflicts of interest None.