

IMPROVING THE PERIPARTUM PATHWAY FOR OBSTETRIC JEHOVAH'S WITNESSES

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INTRODUCTION

Obstetric haemorrhage continues to be one of the leading causes of direct maternal death [1] and obstetric Jehovah's Witnesses (JW) have been shown to be at increased risk of maternal morbidity and mortality from this. [2]

We sought to evaluate obstetric care of Jehovah's Witnesses at our tertiary obstetric unit in Sheffield. We identified key areas for improvement within the peripartum pathway for these patients through multidisciplinary team working between the anaesthetic, obstetric, midwifery teams and the Hospital Liaison Committee (HLC) for Jehovah's Witnesses.

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METHODS

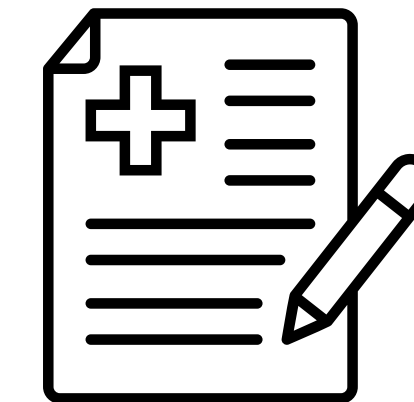
Eligible patients from 2010 to 2024 were identified. Patient consent for publication was obtained through the HLC and the project was approved by the local Caldicott Guardian.

We collected information on risk factors for obstetric haemorrhage, management of anaemia, mode of delivery, estimated blood loss at delivery and whether medical or surgical intervention for haemorrhage was required. This was audited against standards set out in our local guidance. [3]

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RESULTS

12 patient case notes were reviewed, with 18 deliveries in total.



Antepartum phase

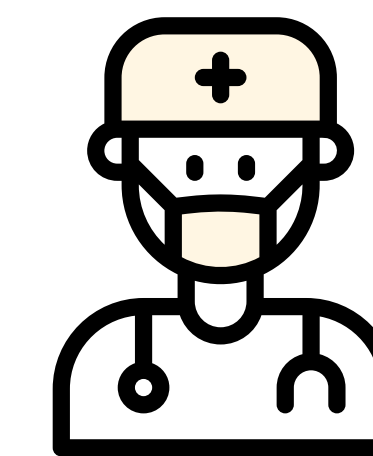
Booking Hb: average 130 g/L

Iron supplementation: < 50% on iron supplementation

Pre-delivery Hb: average 120 g/L (1 patient with Hb < 110 g/L)

Management of pre-delivery anaemia with Ferrinject: none

All patients signed an advance directive for refusal of blood and none of the patients had been seen in the high-risk obstetric anaesthesia clinic.



Intrapartum phase

Mode of delivery: 100% NVD (5 forceps, 1 ventouse)

Average maternal blood loss (MBL): 800ml

- Mild PPH (500-999ml): 6
- Moderate PPH (1000-1999ml): 5
- Severe PPH (> 2000ml): 1*

Limited use of TXA prior to WOMAN-trial, limited use of cell salvage

*TXA, cell salvage, ROTEM, fibrinogen concentrate used for patient with severe PPH



Postpartum phase

Management of post-partum anaemia

- Post-op Hb appropriately measured when indicated
- Ferrinject and erythropoietin offered for Hb < 90 and 70 g/dL respectively

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DISCUSSION / FUTURE PLANS

Key areas identified for improvement were:

- **Peripartum optimisation** of haemoglobin
- Comprehensive **antenatal counselling of alternatives to blood transfusions**, such as cell salvage and fractionated products like fibrinogen concentrate
- **Proactive management** of obstetric haemorrhage in JW patients

Shared multi-disciplinary care of the obstetric JW patient is key to the effective implementation of blood conservation strategies. Of note, the Hospital Liaison Committee (HLC) can be a valuable supportive resource available to clinicians and patients alike, even in acute haemorrhage situations. Learning points from our case series can also be applied to other patient populations who decline or are not able to safely receive blood transfusions.

Plans for improving peripartum pathway:

- **Update local guidance** to include techniques such as vaginal cell salvage
- Develop a **checklist** to facilitate improved peripartum management of anaemia and haemorrhage for obstetric JW patients
- Develop **patient information leaflet** on blood products with HLC liaison

