Scottish National Blood Transfusion Service
Policy Record

Ref: NATP CLIN 11 021 02
Cat: Clinical

Title:

INDICATIONS FOR THE USE OF CMV SERONEGATIVE BLOOD COMPONENTS

Statement:

The Advisory Committee on Safety of Blood Tissues and Organs (SaBTO) reviewed the indications for the use of Cytomegalovirus (CMV) seronegative blood components (red cell concentrate and platelets) and published their recommendations in March 2012. This policy summarises those recommendations, and indicates how they have been adopted by SNBTS in deciding when a patient requires CMV seronegative blood components.

Policy Agreement	CGSC: 7th June 2016	SMT: N/A
Supersedes Policy Ref:	NATP CLIN 11 021 01	
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The SaBTO recommendations are as follows:

1. Indications Where CMV Seronegative Components Are No Longer Required

   The SaBTO recommendation is that in view of the introduction of universal leucodepletion in 1999, coupled with the improved monitoring of immunosuppressed patients and the availability of treatment for CMV infection, it is no longer necessary to provide CMV seronegative red cell and platelet components for patients undergoing haematopoietic stem cell transplantation, solid organ transplantation, congenital or acquired immune deficiencies or malignant disease.

2. Indications Where CMV Seronegative Components May Be Required

   CMV seronegative red cell and platelet components should be used for intrauterine and neonatal transfusion (including exchange transfusions) up to 28 days post expected date of delivery where CMV negative monitoring and treatment of the recipient is more difficult.

   The Guidelines for the Blood Transfusion Services in the UK (8th edition) indicate that CMV seronegative components should be provided for infants up to 1 year of age, and this position is endorsed by the BCSH Transfusion guidelines for neonates and older children (2014). It is therefore SNBTS policy to continue to provide CMV seronegative components to this group of recipients.

   In respect of pregnant women, the objective is to manage the risk of congenital CMV infection in the foetus following primary maternal infection. Therefore, if pregnant women are transfused electively during pregnancy, CMV seronegative red blood and platelet components should be used. Most of these elective transfusions will be for mothers with thalassaemia or sickle cell disease. The vast majority of obstetric transfusions occur at the time of birth and there is no requirement to use CMV seronegative components in this context.

   It is recognised that occasionally pregnant women will receive transfusion in an emergency situation and it is not always possible to access CMV seronegative red cell and platelet components in the clinical timeframes available. In this context, patients should receive standard leucodepleted red cell and platelet components.

   The SaBTO position statement and the Guidelines for the Blood Transfusion Services in the UK (8th edition) indicate that CMV seronegative granulocyte components should be considered for CMV seronegative recipients. However, it is SNBTS policy to provide all granulocyte components as CMV seronegative products, irrespective of the CMV status of the recipient.

   Details of the SaBTO recommendations can be viewed on the SaBTO website http://www.dh.gov.uk/health/2012/03/sabto/