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Perioperative Autologous Transfusion Service: A Logical Extension of our Role in the Operating Room

To the Editor:—Green¹ is to be commended for his enthusiastic endorsement of procedures long used by anesthesiologists to decrease the transfusion of allogenic (homologous) blood perioperatively. Caution, however, should be exercised in accepting his suggestion that anesthesiologists extend their efforts to assuming total responsibility for perioperative cell saving.

When preparing his American Association of Blood Banks (AABB)-mandated quality control program, Dr. Green may have been unaware of the AABB *Guidelines for Blood Salvage and Reinfusion in Surgery and Trauma*² subsequently endorsed by the National Heart, Lung, and Blood Institute (NHLBI) Expert Panel on the Use of Autologous Blood, which specifies the staffing requirements for operating cell-washing devices. The NHLBI document states: "It is essential to have a trained, dedicated operator to operate the equipment, even the newer, automated models."³ The operation of the cell-saving apparatus, like the administration of an anesthetic, demands one's undivided, uninterrupted attention. This may preclude Green's suggestion that: "it is possible, in certain cases, to perform the anesthetic and operate the autotransfusion machine simultaneously."

Anesthesiologists should carefully consider the financial aspects of assuming responsibility for a cell-saving operation. Although Dr. Green may have saved the US Air Force \$15,000–20,000 in the first year of service, such savings may not extend to other situations. Many large institutions already use perfusionists or anesthesia technicians who are trained to operate cell savers, and others have contracts for

the provision of such services. The cost of these services may be reimbursable as a portion of the overall cost of operating the facility. There may, therefore, be no real dollar saving to the institution. When such a pass-through is not permissible, a group of anesthesiologists should consider the worth of such "value added" service in relation to the commitment required (providing around-the-clock coverage) for minimal financial return. In addition, the potential of increased exposure to liability claims must be considered.

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In Reply:—I appreciate Dr. Zauder's comments, and I am aware of the AABB/NHLBI guidelines; however, I do not agree with them. I taken them at their face value; only as guidelines and more importantly, not standards. "Guidelines are *recommendations* (italics added) for patient management that may identify a particular management strategy or a range of management strategies . . . Variances from practice parameters may be acceptable based on the judgment of the responsible anesthesiologist." All guidelines should be interpreted within the context of total patient care.

When I manage the cell-salvage machine, whether I medically supervise a CRNA or perform the anesthetic myself, I believe I provide better care to the patient. I have a heightened awareness of the blood loss, blood volume, and hemodynamic status of the patient. Further, after almost 2 years of involvement in cell salvage and after speaking with numerous OR/anesthesia technicians, OR nurses, perfusionists, and autotransfusionists throughout the country, I believe these guidelines are widely ignored. Perhaps these guidelines are widely ignored

because they are based on older machines that are less automated or viewed as too restrictive and unrealistic in today's economic climate and therefore are irrelevant. As half of our anesthesia group is now trained and certified on the autotransfusion machine, our surgical colleagues have the convenience in an emergency to arrange for cell salvage on short notice (15 min) without having to contact a local perfusion or autotransfusion contract group and hoping that somebody will be available within a reasonable amount of time. It is for these reasons that I propose that the anesthesiology service consider assuming this intraoperative service.

When stating, "it is possible in certain cases, to perform the anesthetic and operate the autotransfusion machine simultaneously," I was specifically referring to those cases in which blood loss is slow but constant. I do not think it is safe to simultaneously perform the anesthetic and run the machine in cases where large blood loss can occur acutely such, as in major vascular cases. With the advanced technology and full automation of the newest machines, I still believe