Anemia and Blood Transfusion in Critically Ill Patients

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Anemia is a common problem in critically ill patients admitted to intensive care units (ICUs).1,2 Delerious effects of anemia include increased risk of cardiovascular morbidity3,4 and mortality, as well as a generalized decrease in oxygen-carrying capacity. Consequences of anemia may be compounded in this population since critical illness often increases metabolic demands.

Among the many causes of anemia in the critically ill, some of the most important are sepsis,4 overt or occult blood loss (including frequent blood sampling5), decreased production of endogenous erythropoietin, and immune-associated functional iron deficiency.6 However, the specific impact of anemia on ICU patient morbidity and mortality is poorly defined, as is the optimal hemoglobin level for this population.

Anemia is typically treated with blood transfusions to help maintain adequate oxygen delivery. Groeger et al7 found that 16% of patients in medical ICUs and 27% of those in surgical ICUs had hemoglobin concentrations less than 10 g/dL. The transfusion rate during the ICU period was 37.0% (1307/3534). Older patients and those with a longer ICU length of stay were more commonly transfused. Both ICU and overall mortality rates were significantly higher in patients who had vs had not received a transfusion (ICU rates: 18.5% vs 10.1%, respectively; χ²=50.1; P<.001; overall rates: 29.0% vs 14.9%, respectively; χ²=88.1; P<.001). For similar degrees of organ dysfunction, patients who had a transfusion had a higher mortality rate. For matched patients in the propensity analysis, the 28-day mortality was 22.7% among patients with transfusions and 17.1% among those without (P=.02); the Kaplan-Meier log-rank test confirmed this difference.

Conclusions This multicenter observational study reveals the common occurrence of anemia and the large use of blood transfusion in critically ill patients. Additionally, this epidemiologic study provides evidence of an association between transfusions and diminished organ function as well as between transfusions and mortality.

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are transfused on any given day. In a retrospective chart review in the United States, 85% of patients with an ICU length of stay greater than 1 week received at least 1 blood transfusion, and the mean number of units of blood transfused per patient was 9.5. More than two thirds of ICU transfusions were not associated with acute blood losses.8

While blood transfusions are prevalent among ICU patients, the criteria for optimal anemia management are not clearly defined.9 A randomized controlled trial by the Canadian Critical Care Trials Group10 comparing restrictive (ie, target hemoglobin level, 7-9 g/dL) and liberal (target level, 10-12 g/dL) transfusion strategies in ICU patients indicated that the liberal use of transfusions may have resulted in higher hospital mortality rates.

The use of blood includes health risk and has significant administrative, logistic, and economic implications. Allogeneic blood transfusion is associated with risk of allergic reaction,11 infection transmission,12 and immunosuppression.11,13,14 Additionally, blood transfusion in the critically ill, particularly with "old" stored cells, does not consistently improve tissue oxygenation.15

The use of blood transfusions for the treatment of anemia in critically ill patients warrants further evaluation. This prospective observational study was designed to determine the frequency of blood drawing and the associated volume of blood lost. The number of blood draws and volume per draw was recorded for all patients in each ICU for a 24-hour period 1 week prior to the anemia and blood transfusion study. Data were also collected for the Sequential Organ Failure Assessment (SOFA) score.16

Blood Sampling Study
The purpose of the blood sampling study was to determine the frequency of blood drawing and the associated volume of blood lost. The number of blood draws and volume per draw was recorded for all patients in each ICU for a 24-hour period 1 week prior to the anemia and blood transfusion study. Data were also collected for the Sequential Organ Failure Assessment (SOFA) score.16

Anemia and Blood Transfusion Study
For all patients admitted to participating ICUs during a 2-week period (November 15, 1999, through November 29, 1999), data were collected daily for a maximum of 28 days or until hospital discharge, interinstitutional transfer, or death. Data collected at ICU admission included demographics, type of admission, type of surgery (if applicable), primary diagnostic category, comorbidities, history of anemia and recent acute blood loss, Acute Physiology and Chronic Health Evaluation II (APACHE II) score, SOFA score, and history of recombinant human erythropoietin therapy. Data collected daily included morning hemoglobin, hematocrit, RBC count, SOFA score, indication for transfusion, pretransfusion hemoglobin (if different from the patient's morning value), and number of units transfused. The primary indication for transfusion (assessed by the attending physician) and pretransfusion hemoglobin levels were collected for the first transfusion of the day only.

Data Management and Statistical Evaluation
Data collected using preprinted case report forms (CRFs) were verified using a series of domain and consistency edits as defined by the study steering committee. Intensive care units were queried when data values were either questionable or were missing for required fields. The CRFs were then scanned electronically using TELEform scanning software (Cardiff Software Inc, Vista, Calif) and a database was created using SPSS v9.01 (SPSS Inc, Chicago, Ill). Unanswered queries concerning required fields were treated as missing and resulted in an overall loss of 0.06% of data.

Descriptive statistics were computed for all study variables. Bivariate and multivariate distributions were evaluated for normality using standard statistical methods and by examining stratified distribution plots. Non-parametric measures of comparison were used for variables evaluated as not normally distributed. Difference testing between groups was performed using the 2-tailed t test, analysis of variance (with Bonferroni post-hoc analyses), or χ² test. Significance for main effects was tested at the α = .05 level. Logistic regression was conducted to assess determinants of mortality. Kaplan-Meier survival analyses were conducted on the entire sample as well as on a sample of matched pairs of patients (transfused and nontransfused) who were matched on their propensity to receive a transfusion. Propensity scores were obtained through logistic regression of patient characteristics as defined by the study steering committee (ie, actual receipt of a transfusion). A greedy matching technique17 was used to match unique transfused patients with unique nontransfused patients based on propensity scores. The best-match propensity score was identical to 6 digits. Once a match was made, the control patient was removed from the pool. This process was then repeated using 5-digit
matching, then 4-digit matching, etc. If a transfused patient matched with more than 1 control, a match was randomly selected. The process proceeded sequentially to a single-digit match on propensity score. If a match was not obtained at this point, the transfused patient was excluded.

Cohorts reflecting patient groups of specific clinical interest were created post hoc. In particular, cohort was defined of those patients with acute bleeding as an indicator for transfusion at any time or having hemorrhagic shock on admission.

RESULTS
TABLE 1 describes the country participation and the characteristics of the participating ICUs.

Blood Sampling Study
Twenty-four-hour blood sampling data were collected on 1136 patients from 145 participating western European ICUs (see list at end of article). The number and volume of blood samples drawn in the 24-hour period varied widely across patients. A total of 45.9% of patients had 5 or more blood samples drawn. The mean (SD) number of draws per patient was 4.6 (3.2), the mean volume per draw was 10.3 (6.6) mL, and the average total volume was 41.1 (39.7) mL for the 24-hour period. There was a significant positive correlation between organ dysfunction (as measured by the SOFA score) and number of blood draws (r = 0.34; P < .001) and total volume drawn (r = 0.28; P < .001).

Anemia and Blood Transfusion Study
Demographics. Anemia and blood transfusion study data were collected on 3534 patients from 146 ICUs. Mean (SD) patient age was 61 (17) years, with 33.4% older than 70 years. The majority of patients (62%) were men. TABLE 2 presents the primary clinical data on admission to the ICU. The mean admitting APACHE II score was 14.8 (7.9) and the mean admitting SOFA score was 5.2 (3.8). Overall mean ICU length of stay was 4.5 (6.7) days (≤1 day, 46.6% of patients; 2-3 days, 21.4%; 4-7 days, 14.2%; and >7 days, 17.8%).

Course of Anemia. The mean (SD) admitting hemoglobin level was 11.3 (2.3) g/dL, with 63% (2078/3295) of patients having an admitting hemoglobin level less than 12 g/dL and 29% (963/3295) less than 10 g/dL. Admitting hemoglobin was correlated with age (r = −0.21; P < .001). The mean admitting hemoglobin level was 11.7 g/dL for patients younger than 50 years (n = 726), but 11.0 g/dL in patients aged 80 through 90 years (n = 298), and 9.9 g/dL in patients older than 90 years (n = 23) (F = 6.6; P < .001).

On admission, approximately 13% of patients had a recent history of anemia; of those patients, 36.6% had an admitting hemoglobin less than 10 g/dL. Of all patients with an admitting hemoglobin level less than 10 g/dL, 48.9% had neither a history of anemia nor of acute bleeding.

Hemoglobin patterns over the 28-day period, stratified by the day 1 hemoglobin level, are illustrated in FIGURE 1, revealing a convergence of hemoglobin levels over time, irrespective of the admitting hemoglobin level. Hemoglobin evolution was similar both for the cohort of patients without acute bleeding (73% of patients, n = 2653) and the cohort with acute bleeding (data not shown). There were weak negative correlations between admitting hemoglobin level and admitting SOFA score (r = −0.21, P < .001) and ICU length of stay (r = −0.25, P < .001).

Table 1. Summary of Participating Institutions*

*ICU indicates intensive care unit; ellipses, not applicable.

Country Characteristics

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
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<tbody>
<tr>
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<td>Belgium</td>
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</tr>
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<td>France</td>
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<tr>
<td>The Netherlands</td>
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<td>116</td>
<td>397</td>
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<td>Norway</td>
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<td>14</td>
<td>30</td>
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<td>Portugal</td>
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<td>Spain</td>
<td>6</td>
<td>58</td>
<td>147</td>
</tr>
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<td>Sweden</td>
<td>3</td>
<td>8</td>
<td>76</td>
</tr>
<tr>
<td>Switzerland</td>
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<td>17</td>
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</tr>
<tr>
<td>United Kingdom†</td>
<td>15</td>
<td>97</td>
<td>273</td>
</tr>
<tr>
<td>Total</td>
<td>146</td>
<td>1136</td>
<td>3534</td>
</tr>
</tbody>
</table>

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Transfusions. The transfusion rate (proportion of 3534 patients transfused) during the ICU period was 37.0%, and the post-ICU transfusion rate was 12.7% (proportion of all patients initially admitted to the ICU). The overall transfusion rate (including both ICU and post-ICU timeframes) was 41.6% over the 28-day period. The mean (SD) age of blood transfused in the ICUs was 16.2 (6.7) days. Leukocyte-depleted blood was used most of the time by 46% of the ICUs surveyed, some of the time in 35%, and never in 19%. Transfusion rates differed significantly by hospital type, with community hospitals transfusing at a rate of 36.4%, regional hospitals at a rate of 39.8%, and academic hospitals at the highest rate of 44.2% (χ^2 = 12.1; P < .002), which reflected the differences in severe-
ity of the patient populations as measured by mean admitting SOFA score across the hospital types (4.5 for patients in community hospitals, 5.1 for patients in regional hospitals, and 5.4 for patients in academic hospitals; F=9.2; P<.001).

Two thirds of patients transfused within 24 hours prior to ICU admission had subsequent transfusions during the survey. Patients admitted for emergency surgery were transfused more frequently (57.5%), followed by those admitted for trauma (48.0%), elective surgery (42.1%), and medical reasons (32.0%). These differences were statistically significant (\(\chi^2=115.0; P<.001\)).

Transfusion rates increased consistently by age group, from 29.9% (18-30 years) to 54.2% (>80 years) \(\chi^2=63.2; P<.001\). However, differences in the mean number of units transfused by age, during both the ICU stay and throughout the 28-day survey, were not statistically significant.

Transfused patients were older, had higher admitting SOFA and APACHE II scores, lower admitting hemoglobin levels, and longer hospital lengths of stay (Table 3).

The overall mean pretransfusion hemoglobin levels were 8.4 (1.3) g/dL for the entire population and 8.5 (1.1) g/dL for those without acute bleeding. Table 4 shows the distribution of indications for transfusion as well as the pretransfusion hemoglobin levels for both the ICU and the post-ICU periods. There were no significant differences in the mean pretransfusion hemoglobin levels by age, primary admitting diagnosis, or indication for transfusion (data not shown). Pretransfusion hemoglobin concentrations exceeded 9 g/dL in less than 30% of cases.

Higher transfusion rates were associated with increased ICU length of stay (Table 5). Mean ICU length of stay for transfused patients was 7.2 (median = 3) days compared with 2.6 (median = 1) days for nontransfused patients. Nearly 70% of all transfused patients received their first transfusion within the first 2 days in the ICU. Patients whose ICU length of stay was longer than 7 days had an overall transfusion rate of 73.3%, with a transfusion rate of 52.6% during the first 2 days in the ICU.

The association between transfusion rates and degree of organ failure, as assessed by the SOFA score, was statistically significant \(\chi^2=358.5; P<.001\). When transfused and nontransfused patients were paired within strata of their admitting SOFA scores, transfused patients had lower mean admitting hemoglobin levels than nontransfused patients at every admitting SOFA category (t tests significant at \(P<.05\) within each SOFA category). Within each admitting SOFA category, the nontransfused groups consistently showed greater improvement in organ function over time than the transfused groups (data not shown). Mean daily SOFA scores were significantly higher in transfused patients than in nontransfused patients across the entire 28-day survey (\(P<.01\) on all 28 days). Transfused patients both with and without bleeding had similar SOFA evolution (data not shown). The last recorded SOFA score, irrespective of length of stay, was significantly lower in the nontransfused group than in the transfused group (2.8 vs 4.8; \(t=-12.8; P<.001\)).

Mortality. ICU mortality was 13.5% and 28-day overall mortality was 20.2%. Both ICU and overall mortality rates were significantly higher for trans-

**Table 3. Patient Characteristics by Transfusion Status**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Transfused</th>
<th>Not Transfused</th>
<th>P Value†</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, mean (SD), y</td>
<td>63.6 (15.8)</td>
<td>59.2 (17.0)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Men, No. (%)</td>
<td>920 (63.3)</td>
<td>1231 (60.6)</td>
<td>.11</td>
</tr>
<tr>
<td>Admission characteristics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admitting Hb level, mean (SD), g/dL</td>
<td>10.1 (2.1)</td>
<td>12.2 (2.1)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Admitting SOFA score, mean (SD)</td>
<td>6.6 (3.7)</td>
<td>4.2 (3.5)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Admitting APACHE II score, mean (SD)</td>
<td>16.5 (7.9)</td>
<td>13.5 (7.7)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Recent history of anemia, No. (%)</td>
<td>254 (17.5)</td>
<td>188 (9.2)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Recent history of blood loss, No. (%)</td>
<td>594 (4.1)</td>
<td>353 (17.4)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>In shock at admission, No. (%)</td>
<td>445 (30.7)</td>
<td>258 (12.7)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Admission type, No. (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elective surgery</td>
<td>617 (41.9)</td>
<td>847 (41.1)</td>
<td>.61</td>
</tr>
<tr>
<td>Emergency surgery</td>
<td>338 (23.3)</td>
<td>248 (12.0)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Medical</td>
<td>368 (25.0)</td>
<td>731 (37.9)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Trauma</td>
<td>129 (8.8)</td>
<td>140 (6.8)</td>
<td>.03</td>
</tr>
<tr>
<td>Other</td>
<td>16 (1.1)</td>
<td>42 (2.0)</td>
<td>.03</td>
</tr>
<tr>
<td>Hospital length of stay, mean (SD), d</td>
<td>15.8 (6.0)</td>
<td>10.9 (7.9)</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

*Hb indicates hemoglobin; SOFA, Sequential Organ Failure Assessment; and APACHE II, Acute Physiology and Chronic Health Evaluation II.*

†Due to missing data, the group sizes vary for each comparison.

**Table 4. Summary of Indications for Transfusion**

<table>
<thead>
<tr>
<th>Indication for Transfusion†</th>
<th>ICU Transfusion (n = 1307)</th>
<th>Post-ICU Transfusion (n = 326)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Transfusions, No. (%)</td>
<td>Pretransfusion Hb, Mean (SD), g/dL</td>
</tr>
<tr>
<td>Acute bleeding</td>
<td>702 (55.5)</td>
<td>8.4 (1.4)</td>
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<tr>
<td>Inadequate Hb with:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diminished physiological reserves</td>
<td>355 (28.0)</td>
<td>8.4 (1.0)</td>
</tr>
<tr>
<td>Altered tissue perfusion</td>
<td>213 (16.8)</td>
<td>8.4 (1.2)</td>
</tr>
<tr>
<td>Coronary artery disease</td>
<td>104 (8.2)</td>
<td>8.7 (0.9)</td>
</tr>
<tr>
<td>Other indications</td>
<td>142 (11.2)</td>
<td>8.4 (1.2)</td>
</tr>
</tbody>
</table>

*ICU indicates intensive care unit; Hb, hemoglobin.*

†Since many patients were transfused on multiple days, indications for transfusions are not mutually exclusive.

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fused vs nontransfused patients (ICU: 18.5% vs 10.1%, respectively; $\chi^2 = 50.1; P < .001$; overall: 29.0% vs 14.9%, respectively; $\chi^2 = 88.1; P < .001$). Higher 28-day mortality rates in transfused patients than in nontransfused patients persisted across all SOFA categories in all but the sickest patients (data not shown).

The 28-day survival curves differed significantly by admitting hemoglobin category in transfused patients (Kaplan-Meier log-rank $= 30.3; P < .001$) but not in nontransfused patients. Mortality rates were higher in transfused patients than in nontransfused patients at every hemoglobin category. There was a dose-response relationship between the number of RBC units transfused and mortality, with patients receiving the most units having the highest mortality rates (Table 6).

Hierarchical logistic regression was conducted to determine the associations between various patient characteristics and death in the ICU. In the first step, patients’ admission characteristics (age, admitting hemoglobin level, APACHE II score, and SOFA score) were entered into the model; in the second step, transfusion status (yes/no) was entered. In this model (Table 7), the associations of transfusion, APACHE II, SOFA, and age with mortality were statistically significant but admitting hemoglobin level was not.

Receipt of a transfusion in the ICU increased a patient’s odds of dying by a factor of 1.37 (95% confidence interval, 1.02-1.84).

To examine the specific association between transfusion and mortality, propensity scores$^{18}$ were used to adjust for differences in all observed background characteristics in the estimation of the effects of transfusion. A logistic regression model was used to generate a propensity score that reflected the probability of being transfused for each patient. Variables chosen were age, sex, admission type, diagnosis on admission, admitting SOFA score, admitting APACHE II score, day 1 hemoglobin concentration, recent history of anemia, recent acute blood loss, whether the patient was in shock on admission, and hospital length of stay. The logistic regression model was able to correctly classify 76% of patients and produced a Nagelkerke $R^2$ of 0.415. The probability of being transfused ranged from 0.01 to 0.97.

The matching process yielded 516 unique transfused and 516 unique nontransfused patients who were matched by their propensity scores. Post-matched comparisons of patient characteristics (from Table 3) are presented in Table 8 and illustrate that the differences between transfused and nontransfused patients along these parameters were no longer evident.

Among the matched patients, 205 died during the 28-day follow-up period. Mortality of the transfused patients was 22.7% vs 17.1% for nontransfused patients ($\chi^2; = 5.1; P = .02$). In other words, of those who died, 57.1% were transfused, and 42.9% were not.

### Table 5. Intensive Care Unit (ICU) Transfusion Rate and Mean Number of Units Transfused by ICU Length of Stay (LOS)

<table>
<thead>
<tr>
<th>ICU LOS, d</th>
<th>All Patients (n = 3534)</th>
<th>Acute Bleeding (n = 794 [22.5%])*</th>
<th>No Acute Bleeding (n = 2655 [75.1%])*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. Transfused, Mean No. (SD)</td>
<td>Transfused, %†</td>
<td>Units Transfused, Mean No. (SD)†</td>
</tr>
<tr>
<td>All patients</td>
<td>3534</td>
<td>37.0</td>
<td>4.8 (5.2)</td>
</tr>
<tr>
<td>≤2</td>
<td>2136</td>
<td>24.5</td>
<td>2.9 (2.6)</td>
</tr>
<tr>
<td>&gt;2</td>
<td>1398</td>
<td>56.1</td>
<td>6.0 (6.1)</td>
</tr>
<tr>
<td>&gt;7</td>
<td>629</td>
<td>73.5</td>
<td>7.2 (7.5)</td>
</tr>
</tbody>
</table>

*Numbers do not total 3534 because of missing data (some forms incomplete). 

### Table 6. Difference in Mortality by Number of Units Transfused

<table>
<thead>
<tr>
<th>Units Transfused</th>
<th>No. Survived (n = 2422)</th>
<th>% Survived</th>
<th>No. Died (n = 614)</th>
<th>% Died</th>
<th>P Value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1896</td>
<td>85.1</td>
<td>14.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>157</td>
<td>84.1</td>
<td>15.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>377</td>
<td>79.6</td>
<td>20.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>157</td>
<td>70.7</td>
<td>29.3</td>
<td></td>
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</tr>
<tr>
<td>4</td>
<td>130</td>
<td>69.2</td>
<td>30.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;4</td>
<td>319</td>
<td>55.2</td>
<td>44.8</td>
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</table>

*Total does not add to 100% since 2.4% of patients had missing data related to bleeding status.

### Table 7. Summary of Logistic Regression on Mortality*

<table>
<thead>
<tr>
<th>Variable</th>
<th>β</th>
<th>SE</th>
<th>Wald $x^2$</th>
<th>P Value</th>
<th>OR (95% CI)</th>
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<tr>
<td>Constant</td>
<td>−6.71</td>
<td>0.52</td>
<td>168.57</td>
<td>&lt;.001</td>
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<tr>
<td>Transfusion</td>
<td>0.31</td>
<td>0.15</td>
<td>4.28</td>
<td>.04</td>
<td>1.37 (1.02-1.84)</td>
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<tr>
<td>Admitting SOFA score</td>
<td>0.26</td>
<td>0.02</td>
<td>119.43</td>
<td>&lt;.001</td>
<td>1.30 (1.24-1.36)</td>
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<tr>
<td>Admitting APACHE II score</td>
<td>0.11</td>
<td>0.01</td>
<td>106.02</td>
<td>&lt;.001</td>
<td>1.11 (1.09-1.14)</td>
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<tr>
<td>Age</td>
<td>0.01</td>
<td>0.00</td>
<td>4.38</td>
<td>.04</td>
<td>1.01 (1.00-1.02)</td>
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<tr>
<td>Admitting Hb</td>
<td>0.04</td>
<td>0.03</td>
<td>1.35</td>
<td>.24</td>
<td>1.04 (0.98-1.10)</td>
</tr>
</tbody>
</table>

*Nagelkerke $R^2 = 0.440; \chi^2 = 815.87; P < .01; 89.43% correctly classified. OR indicates odds ratio; CI, confidence interval; NA, not applicable; SOFA, Sequential Organ Failure Assessment; APACHE II, Acute Physiology and Chronic Health Assessment II; and Hb, hemoglobin.
**Figure 2** illustrates the different survival curves for the matched transfused and nontransfused patients. The Kaplan-Meier log-rank statistic testing the equality of the survival distributions for the matched groups was 3.99 ($df = 1$; $P = .05$), indicating significantly different survival patterns.

**COMMENT**

**Course of Anemia**

This large, epidemiologic study in European ICUs validates the common occurrence of anemia in critically ill patients and also reports that lower mean hemoglobin levels were associated with higher SOFA scores, longer lengths of stay, and higher mortality rates.

Our findings also underline that blood loss through blood sampling is considerable, averaging 41 mL per day. Sicker patients had more blood draws per 24 hours resulting in a higher total loss of blood than patients of lower acuity. Mechanisms to reduce blood sampling losses can include use of point-of-care testing and microchemistry techniques, use of tubing that eliminates the need for discard, a thorough knowledge and communication of the minimum volume needed for each laboratory test, and storage of blood specimens for potential subsequent use. Education and guideline development on such sparing mechanisms may lead to greater implementation.

**Transfusion**

The overall transfusion rate during the 28-day study period was 42%, with an ICU transfusion rate of 37%. While most transfusions were given within the first week of ICU admission, many transfusions continued to be given throughout the 28-day follow-up period. In patients with ICU length of stay longer than 1 week, 73% received a blood transfusion. This is slightly lower than the rate found in a 1995 study by Corwin et al, in which 85% of US patients with length of stay longer than 1 week received a blood transfusion.

The overall mean pretransfusion hemoglobin level was 8.4 g/dL, a value perhaps lower than expected. Actually, the distribution of pretransfusion hemoglobin levels indicated that transfusions were given at a hemoglobin level greater than 9 g/dL in less than 30% of cases. The important results of the Canadian Critical Care Trials Group have probably influenced practice. Surprisingly, there was no significant difference in the mean pretransfusion hemoglobin by age, primary admitting diagnosis, or indication for transfusion. Even patients whose transfusion indication was acute bleeding had pretransfusion hemoglobin levels similar to those of patients who had other indications for transfusion. Hence, it seems that the hemoglobin value is still the major determinant of the decision to transfuse.

While elderly patients had pretransfusion hemoglobin levels similar to those of younger patients, they had lower daily mean hemoglobin levels than younger patients (ie, had a higher incidence of reaching the transfusion threshold). 

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**Table 8. Patient Characteristics by Transfusion Status for Propensity-Matched Patients**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Transfused</th>
<th>Not Transfused</th>
<th>P Value†</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, mean (SD), y</td>
<td>64.0 (15.5)</td>
<td>64.1 (15.0)</td>
<td>.10</td>
</tr>
<tr>
<td>Men, No. (%)</td>
<td>193 (37.4)</td>
<td>203 (39.3)</td>
<td>.52</td>
</tr>
<tr>
<td>Admission characteristics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admitting Hb level, mean (SD), g/dL</td>
<td>10.8 (2.0)</td>
<td>10.9 (1.8)</td>
<td>.92</td>
</tr>
<tr>
<td>Admitting SOFA score, mean (SD)</td>
<td>5.5 (3.3)</td>
<td>5.5 (4.0)</td>
<td>.92</td>
</tr>
<tr>
<td>Admitting APACHE II score, mean (SD)</td>
<td>14.6 (7.0)</td>
<td>12.0 (7.5)</td>
<td>.54</td>
</tr>
<tr>
<td>Recent history of anemia, No. (%)</td>
<td>80 (15.5)</td>
<td>66 (12.8)</td>
<td>.21</td>
</tr>
<tr>
<td>Recent history of red blood loss, No.</td>
<td>162 (31.4)</td>
<td>170 (32.9)</td>
<td>.59</td>
</tr>
<tr>
<td>In shock at admission, No. (%)</td>
<td>117 (22.7)</td>
<td>106 (20.5)</td>
<td>.41</td>
</tr>
<tr>
<td>Admission type, No. (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elective surgery</td>
<td>271 (52.5)</td>
<td>261 (50.6)</td>
<td>.53</td>
</tr>
<tr>
<td>Emergency surgery</td>
<td>83 (16.1)</td>
<td>89 (17.2)</td>
<td>.62</td>
</tr>
<tr>
<td>Medical</td>
<td>128 (24.8)</td>
<td>130 (25.2)</td>
<td>.89</td>
</tr>
<tr>
<td>Trauma</td>
<td>29 (5.6)</td>
<td>31 (6.0)</td>
<td>.79</td>
</tr>
<tr>
<td>Other</td>
<td>5 (1.0)</td>
<td>5 (1.0)</td>
<td>&gt;.99</td>
</tr>
<tr>
<td>Hospital length of stay, mean (SD), d</td>
<td>11.4 (6.8)</td>
<td>12.0 (7.5)</td>
<td>.21</td>
</tr>
</tbody>
</table>

*Hb indicates hemoglobin; SOFA, Sequential Organ Failure Assessment; and APACHE II, Acute Physiology and Chronic Health Evaluation II.*

†For every comparison, n = 516 in each group.

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transfusion, the likely contributing fac-
tor to mortality in the critically ill popu-
lation is related to immunosuppres-
sion as opposed to allergic reaction or
infectious transmission. Red blood cell
transfusion has been associated with a
higher incidence of postoperative in-
fec tion in various populations.25-27 The
use of leukodepleted blood may result
in shorter lengths of stay and fewer
complications.28,29 At the time of this
study, the use of leukocytes in blood in
participating institutions was vari-
able. Variability in storage techniques
may also contribute to RBC deforma-
tility that may influence cell oxygen
availability.

Due to the risks associated with blood
transfusions, alternative treatments of
anemia in the critically ill are being ex-
plored. The administration of exog-
enous human recombinant erythropoi-
etin (epoetin alfa) has been shown to
raise reticulocyte counts20,27 and he-
mocrit levels, and to reduce the total
number of units of transfused blood re-
quired in critically ill patients.30

Interpretation of findings from this
observational study should be limited
to identification and description of asso-
ciations between variables of
interest. No intervention was imple-
mented, no attempt to control or in-
fluence provision of care was made, and
the physicians were not blinded to the
study purpose. Additionally, the ill-
nesses and treatments of the critically
ill are complex and confounded by a
multitude of factors. Moreover, data col-
collection in studies of this design is ne-
cessarily limited, and not all factors that
may have influenced physicians’ trans-
fusing practice may not have been
collected. Therefore, no causal in-
ferences for associations can be drawn.

The findings from this study reveal
that anemia in critically ill patients is
common. Transfusions are also com-
mon, especially in elderly patients and
those with longer ICU lengths of stay.
Even though transfusions currently
seem to be given primarily in re-
response to decreased hemoglobin lev-
els, the trigger for blood transfusions
averaged only 8.4 g/dL. This study pro-
vides evidence of the associations be-
tween transfusion and diminished or-
gan function as well as between low
hemoglobin level, transfusion, and mor-
tality. Clearly, further study is needed to
classify the place of transfusion in
critically ill patients and to evaluate
other treatments for anemia that re-
duce the need for blood transfusions,
such as the use of recombinant hu-
man erythropoietin (epoetin alfa).

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Drafting of the manuscript: Vincent.
Critical revision of the manuscript for important in-
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REFERENCES


