**44ICU TRANSFUSION GUIDELINES UPDATED (REV. 3/2014)**

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| Patient Population | Action |
| Resuscitated patient with stable hemodynamics and NO acute cardiac disease/physiologic stress  Hgb <7 g/dL | Consider transfusion of single unit PRBCs to achieve Hgb > 7g/dL |
| Patient with ASYMPTOMATIC coronary artery disease  Hgb <7-8 g/dL | Consider the transfusion of single units  PRBCs to achieve Hgb > 8g/dL |
| Patient with acute coronary syndrome (STEMI)  Hgb < 8 g/dL | Consider transfusion of single unit of PRBCs to achieve Hgb > 8g/dL and assess ischemia/symptoms. If ongoing ischemia/ symptoms can consider further transfusion until symptoms improve or to Hgb>10g/dL |
| Patient with signs of active bleeding BUT  hemodynamically stable  Hgb < 7.0 g/dL | Consider transfusion of single units  PRBCs. |
| Patient in Hemorrhagic Shock | \*Treat on an individual basis based on clinical picture and amount of bleeding. |
| Patient after Cardiac Surgery | Patient-specific transfusion and hemoglobin goals should be discussed with cardiac surgery team and treated on an individual basis. There is evidence that a hemoglobin threshold of 8mg/dL is safe in this population. |
| Patient with symptomatic anemia (chest pain, orthostatic hypotension or tachycardia unresponsive to fluid resuscitation, or congestive heart failure) *not* attributed to any other underlying condition | Consider transfusion of single units  PRBCs.  \*Transfusions should be titrated to resolution of symptoms or up to Hgb 10g/dL. |
| Patient with severe physiologic stress (sepsis,  burns) | Treat on an individual basis based on clinical picture |

There is no clear evidence that blood transfusion definitively increases tissue oxygenation.

**Transfusion should take into account the entire clinical picture, and using hemoglobin as the *sole* transfusion trigger should be avoided.**

**Sources**

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