



Perioperative Jehovah's Witnesses: a review

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Abstract

There are many patient groups who may refuse blood products; the most well known amongst them is the Jehovah's Witness faith. Treatment of anaemia and bleeding in such patients presents a challenge to medical, anaesthetic, and surgical teams. This review examines the perioperative issues and management of Jehovah's Witnesses. The history and beliefs of Jehovah's Witnesses are outlined together with their impact on ethics and the law, and different management options throughout the perioperative period are discussed.

Key words: blood; coagulopathy; ethics; Jehovah's Witness; transfusion

The Jehovah's Witness religion is a proselytizing Christian movement with approximately 7.8 million members worldwide.¹ They have strongly held beliefs, amongst them a refusal to 'consume' blood. This review aims to present a succinct yet relatively comprehensive overview of the history of the Jehovah's Witness movement in order to provide better understanding of their point of view, the ethical and legal ramifications of their beliefs on clinical practice, and the various treatment options at our disposal, which are not only applicable to Jehovah's Witnesses but to all patients as part of a holistic blood-management strategy.

Relevant literature was identified by a Pubmed search seeking relevant articles in human subjects, written in the English language, and published between January 1966 and October 2013, for the primary search term 'Jehovah's Witness' in conjunction with other relevant search terms, including blood, coagulopathy, ethics, and transfusion. Further relevant work was identified from the reference lists of the principal articles.

History

Charles Taze Russell founded the Jehovah's Witness faith in 1881, the main principles being that the Bible is infallible (philosophically, historically, and scientifically)² and that errors were introduced into all denominations through its misinterpretation. Jehovah's Witnesses generally prefer their own translation, the New World Translation of Holy Scriptures.³ The core Jehovah's Witness beliefs^{3–5} are as follows: (i) Christ's second coming and Armageddon are imminent and involve God restoring humans

and the Earth to the 'perfection' of Eden; (ii) a righteous 144 000 will be resurrected to a 'royal priesthood' in Heaven (specific number mentioned in Revelations), the rest of humanity being resurrected to a lower plane; (iii) the soul is a living thing and may die; and (iv) death is a state of non-conscious, non-existence.

Russell died in 1916 and was succeeded by Joseph Rutherford, who was replaced by Nathan Knorr in 1942, after which control shifted towards a leading council (culminating in 1976).⁶ The following medically relevant doctrines were adopted during this period: (i) blood transfusions were deemed unacceptable in 1944–45;^{7–8} (ii) vaccinations were deemed acceptable in 1952;⁹ and (iii) organ transplants were equated to cannibalism in 1967¹⁰ (deemed a matter of conscience or choice in 1980).¹¹

Changes in doctrine are attributed to 'God's progressive revelations'.¹² Today, the 'Governing Body' of Jehovah's Witnesses, in Brooklyn, New York, leads the organization, overseeing 98 branch offices covering 30 global zones.¹³ Regional congregations oversee specific territories and are led locally by congregational elders.

Beliefs about blood

Jehovah's Witnesses' beliefs regarding blood are based on biblical passages¹⁴ including the following: (i) Genesis 9:4, 'But you shall not eat flesh with its life, that is, its blood.' (ii) Leviticus 17:10, 'If any one of the house of Israel or of the strangers who sojourn among them eats any blood, I will set my face against that person who eats blood and will cut him off from among his people.'

(iii) Acts 15:29, '... that you abstain from what has been sacrificed to idols, and from blood, and from what has been strangled, and from sexual immorality. If you keep yourselves from these, you will do well.'

Jehovah's Witnesses believe that **human blood is sacred** and a potential vector for sin, whereas Christ's blood is Holy and is the only blood that can redeem them.⁵ Jehovah's Witnesses separate **blood into four major components**, namely **red cells**, **white cells**, **platelets**, and **plasma**, which must **not be 'consumed'** in any circumstance, because they may irreversibly compromise their soul.¹⁵ The evolving nature of transfusion medicine has led to modifications of the position of Jehovah's Witnesses on what may be deemed acceptable. The **Watchtower Society (WTS)** states that the use of **blood fractions** is a **personal conscientious decision**. A reader's justification was published in *The Watchtower* in 1990 stating that in a 'natural setting' blood fractions (plasma proteins and bilirubin) move between mother and fetus; and therefore, other minor fractions could potentially be viewed as **acceptable**.¹⁶ Table 1 outlines the variable acceptability of different blood products amongst Jehovah's Witnesses.

Ethical and legal considerations

Bioethics

While one can argue that there is no universal bioethic, in general it is accepted that **Beauchamp and Childress' four principles**¹⁷ are a **sound basis** on which an **ethical problem can** be assessed. Each component is equally weighted and to be followed, unless it conflicts with the others.

- (i) Respect for **autonomy**, including competence, best interests, quality of life and contextual factors, such as religious background; although Muramoto¹⁸ suggests that the individual's wishes are of primary importance and religious considerations should be secondary.

- (ii) **Beneficence** (acting in a way to 'do good' for the patient), taking into account the potential psychosocial ramifications for a Jehovah's Witness regarding transfusion.¹⁸
- (iii) **Non-maleficence**; avoidance of causing harm disproportionate to the benefit of treatment.
- (iv) **Justice**, including the legal position and human rights.

For the purposes of this article, the focus has been kept on the UK, with illustrative examples from elsewhere to highlight the varying situation in other countries.

Capacity and consent

Medical **consent** is a decision or **agreement to allow an intervention** and is not a single event but a **continuously evolving process**. The **ability** to make such a decision is defined as **capacity**. This must be informed and **free from duress**, which may seem difficult given variations in Jehovah's Witness blood education and the presence of family members or Jehovah's Witness elders during consultations. Adults are **assumed to have capacity** until **proved otherwise** and have 'the **right** to make **decisions** that others might **think are unwise**'¹⁹ (**Mental Capacity Act 2005**). Similar positions are upheld in Europe (e.g. Articles 2 and 32, respectively, of the German and Italian constitutions). Interestingly, a survey of 242 members of the European Society of Intensive Care Medicine exploring attitudes to transfusion of exsanguinating Jehovah's Witnesses without consent showed **variation in attitudes**, with **French** and **Italian** Intensivists more **commonly transfusing** than British, Dutch, or Scandinavian counterparts.²⁰

Children and adolescents

Jehovah's Witness children may have little world experience outside of their faith and may not fully appreciate potential risk of death and the dying process that may be associated with refusal of treatment. **Consent for medical intervention** depends on **two**

Table 1 Variable acceptability of different blood products among Jehovah's Witnesses. *Patients may request that continuity is maintained with their vascular system or that the circuit is not primed with allogeneic blood

Generally not acceptable	May be acceptable	Generally acceptable
Red cells	Red cell fractions <ul style="list-style-type: none"> • Haemoglobin (human, animal, or synthetic, e.g. Hemopure®) 	Crystalloids and colloids Recombinant erythropoietin Recombinant factor VIIa Artificial blood substitutes
White cells	White cell fractions <ul style="list-style-type: none"> • Interferons or interleukins 	
Plasma	Plasma fractions <ul style="list-style-type: none"> • Albumin • Immunoglobulins • Cryoprecipitate • Clotting factors 	
Platelets	Platelet fractions <ul style="list-style-type: none"> • Platelet factor 4 Acute hypervolaemic haemodilution Intraoperative cell salvage* Cardiopulmonary bypass or extracorporeal membrane oxygenation* Renal dialysis* Plasmapheresis Epidural blood patch Transplants	

factors: age and urgency of procedure. Adolescents more than 16 yr of age are assumed to be legally competent; however, this does not invalidate the parental right to consent on their behalf. For children less than 16 yr of age, Gillick competence will need to be assessed (the ability to consent to their own medical treatment, regardless of parental permission or knowledge).²¹ Woolley²² proposes the following four competing issues for children less than 16 yr of age: (i) capacity for consent; (ii) parental authority; (iii) prevailing view in the event of dispute between parent and child; and (iv) power of the court.

Similar practices to Gillick competence have been adopted in Australia, Canada, New Zealand, and in certain states of America with the 'mature minor doctrine'. If consent is refused, an application to the High Court for a 'specific issue order' can be made (i.e. parental authority is removed and the procedure may go ahead). If there is not enough time for such an application, then doctors are empowered to act in the 'best interest' of the patient, and blood may be given.²³

The law

The legal situation surrounding consent for medical interventions among Jehovah's Witnesses is complex and can vary significantly between countries. In his conclusion to the Re T Court of Appeal case, Lord Donaldson of Lymington highlights an important principle: 'What matters is that the doctors should consider whether at that time he had a capacity which was commensurate with the gravity of the decision. The more serious the decision, the greater the capacity required'.²⁴ The Re T case highlights that fact that next of kin have no legal right to consent or to refuse consent.²⁴ Administration of blood products against the wishes of a competent patient is a potentially criminal act subject to prosecution. In 1990, Canadian physicians were successfully sued after administering blood transfusions disregarding a Jehovah's Witness's beliefs.²⁵

Two 19th century cases form the basis of current legal precedent regarding children in the UK: (i) the Poor Law Amendment Act²⁶ of 1868 states that parents 'neglecting their children in various ways' (including refusal of medical treatment) may be criminally liable; and (ii) in the case of the Queen vs Robert Downes²⁷ in 1875, Downes was convicted of manslaughter after not seeking medical opinion or treatment (an action based on religious objections), which was felt ultimately led to the death of his son.

Today, parents have the right and duty to give proxy consent for medical interventions,²² although this is not necessarily absolute; the court has prevailing control in terms of consent in acting in the child's best interests.

Blood refusal cards

Introduced by the WTS in the 1970s, blood refusal cards are carried in the same way as organ donor cards. There are conflicting legal cases surrounding informed consent and their validity,^{25 28} because of the accompanying WTS literature, which highlights transfusion risks while neglecting potential benefits. Should the card's validity be doubted in emergency situations, some recommend treating in the patient's best interest and administering blood.²⁹

Advance directives

These are legally binding documents outlining treatments an individual would not consent to in the future, should they lack capacity (outlined by the Mental Capacity Act 2005).¹⁹ They can be made by anyone more than 18 yr of age (16 yr in Scotland)

and are usually kept by the patient's general practitioner, family, or friends. In order to be valid, the following provisos must be met: (i) the individual must have capacity at the time of signing; (ii) the directive must be signed with a witness present; and (iii) the directive must specify the decision applied to a specific treatment if the individual's life is at risk. If any of these conditions is not met, the directive may be invalid.²⁹

Staff

We should also be mindful of the potential profound psychological consequences on the multidisciplinary team where significant morbidity or mortality may result from the restrictions placed on their practice by a patient's beliefs, especially when they may have their own ethical objections in Jehovah's Witness treatment. Provided the clinical situation allows (i.e. elective and non-emergent), alternative arrangements should be made with clinicians who are prepared to be involved.^{30 31} These scenarios highlight the need for a full team briefing before surgery and the possible need for counselling after surgery.²⁹

An approach to Jehovah's witness consultations or preoperative assessment

While we present this as a framework for management of Jehovah's Witnesses, it is important to note that the principles of patient blood management are universal and should be applied to all patients. In Jehovah's Witnesses, the approach depends on whether the scenario is an elective or emergency setting. We outline frameworks for each in Table 2.

Perioperative management

The first step in managing a surgical patient who refuses transfusion is location. Elective surgery should proceed only if the centre has the facility for all elements of patient management. Jehovah's Witnesses (and other patients who refuse transfusion) require a holistic approach across the whole perioperative period (although in elective patients much of the focus will be in preoperative optimization). We outline the specialities that may be involved in their care and the various interventions that can be used in Table 3.

There are four specific aims: (i) to minimize blood loss; to optimize oxygen delivery and consumption; (iii) to enhance haemoglobin (Hb) synthesis and erythropoiesis; and (iv) to correct coagulation defects and promote haemostasis. These should be followed in conjunction with more general aims, such as the optimization of co-morbidities and nutritional state.

Minimization of blood loss

Blood loss increases morbidity, and Spence and colleagues³² showed that mortality throughout the perioperative period increases with blood loss >500 ml irrespective of the preoperative Hb concentration, which is why cessation of blood loss is a top priority.

General principles

If blood loss is suspected in a Jehovah's Witness patient, prompt and senior assessment and intervention is essential.^{30 31} This must include a rationalized approach to ordering blood tests to limit phlebotomy;³³ the use of a paediatric or micro-sample tube and microanalysers has been shown to be effective.^{33 34}

Table 2 Elective and emergency frameworks

Elective framework	Emergency framework
Organize confidential meeting (free from coercion; medical, religious, or familial)	Depends on:
Explain that your opinions are based on current best evidence and practice and your aim is not to be coercive, only informative	<ul style="list-style-type: none"> • Presence of capacity • Patient age • Presence of an advance directive
Discuss the need to optimize haemoglobin before surgery and potential for postponement	Aim for a private discussion with patient or next of kin, free from coercion (medical, religious, or familial)
Establish Jehovah's Witness status, beliefs, and advance directive	Establish urgency and time-sensitive nature of scenario
Establish opinion on blood products, highlighting local availability, experience or inexperience with alternative or novel therapies, etc.	Establish Jehovah's Witness status and position on blood and blood products
Determine what products or procedures are acceptable or unacceptable	Use collateral sources if necessary, including advanced directives and hospital Jehovah's Witness liaison
Explain proposed medical intervention, including pros, cons, risks (including death, disability, and suffering) and alternatives (including no intervention)	Explain clearly the patient's condition, prognosis, and treatment options, including your recommendation
Form worst case scenario plan	Aim for consensus and compromise
Fully document discussion and acceptable options	If consensus and compromise are impossible, consider the patient's best interests with regard to the law
	Fully document discussion, actions, etc.

These patients also require a close degree of monitoring; after surgery, this may involve high-dependency level care.

Medical care

Whilst optimizing other medical co-morbidities, it is important to anticipate and treat other potential vectors of blood loss, for example: (i) **proton pump inhibitors** for gastrointestinal ulceration;³⁵ (ii) **progesterone** for menstruation;³⁶ and (iii) endoscopic or interventional radiological treatments for other types of medical bleeding.^{35–37}

Anaesthetic care

General interventions that may be beneficial include the following.

- (i) Positioning needs to be taken into account because of potential cardiovascular effects that may increase bleeding risk by altering preload, cardiac output, and peripheral vascular resistance.
- (ii) The **mode of ventilation** is important. While mechanical ventilation may avoid hypercapnia and an associated increase in bleeding, it **reverses** intrathoracic pressure, which acts to **decrease venous return and potentially increase venous blood loss**.
- (iii) In the elective setting, **hypothermia** should be **avoided** to prevent the potential for **coagulopathy** and blood loss.

Specific interventions that may be beneficial include the following.

- (i) **Acute normovolaemic haemodilution** involves the removal of blood followed by rapid infusion of colloid or crystalloid to restore plasma volume. Any surgical blood loss will therefore have a lower haematocrit, and previously stored blood can then be reinfused. However, **this may not be acceptable** to Jehovah's Witnesses **unless a closed circuit** is used,^{38–39} despite some evidence to suggest that **it may reduce** the **risk** of allogeneic **transfusion**.^{40–41}

- (ii) Acute **hypervolaemic haemodilution** is a **simpler, acceptable** alternative, which does **not** involve **removal** of the patient's **blood**. Despite small numbers, a study by Entholzner and colleagues⁴² showed **no** statistically significant **differences** between acute **normovolaemic** haemodilution and acute **hypervolaemic** haemodilution.
- (iii) **Hypotensive** anaesthesia is defined as a **systolic** blood pressure of **80–90 mm Hg**, a **mean** arterial pressure of **50–65 mm Hg**, or a **30% reduction** of baseline mean arterial pressure.⁴³ It has been used in a variety of surgical specialties and patient populations (including Jehovah's Witnesses)^{44–45} as a way of reducing perioperative blood loss and improving surgical field visibility. Degoute⁴³ suggests that remifentanyl (as part of a balanced general anaesthetic) or epidural anaesthesia are the two most satisfactory techniques.
- (iv) Regional and **central neuraxial anaesthesia**, when compared with general anaesthesia, are associated **with reduced estimated blood loss** and postoperative transfusion requirement.^{46–47}

Surgical care

The key principle is meticulous haemostasis.³⁰ Other considerations include surgical technique (endoscopic or laparoscopic), use of diathermy,⁴⁸ **ultrasonic scalpels**,⁴⁸ collagen or **cellulose pads** (e.g. Kaltostat),⁴⁹ and **fibrin glues** and **sealants** (e.g. Tisseal).⁵⁰ When surgery is expected to be complex and lengthy, it may be appropriate to consider a **staged** procedure.⁵¹

Equipment

Various pieces of equipment can be used to limit haemorrhage, either prophylactically or actively, as follows.

- (i) Arterial tourniquets have been shown to be useful in Jehovah's Witnesses undergoing peripheral limb or joint surgery.⁵¹
- (ii) **Anti-shock garments** (pneumatic or non-pneumatic) have been used to limit hypovolaemia or haemorrhage in trauma

Table 3 Perioperative management strategies

General principles			
<ul style="list-style-type: none"> • Act promptly to minimize blood loss • Establish Jehovah's Witness status and capacity, competence, legal issues, and advance directive • Determine acceptable therapies • Plan for worst case scenario • Establish cause or source of bleeding; medical or surgical • Provide thorough documentation • Early consultant involvement and referral • Close monitoring and limited phlebotomy • Low threshold for high-dependency unit/intensive care unit 			
Targeted therapies to be enacted simultaneously			
Stop/minimize blood loss	Optimize anaemia tolerance	Enhance haemoglobin and red blood cell production	Correct coagulation defects and promote haemostasis
<ul style="list-style-type: none"> • Prompt surgical intervention • Replace intravascular volume <p>Consider the following:</p> <ul style="list-style-type: none"> • Cell salvage • Washing and reinfusion of drain fluid • Arterial tourniquets • Interventional radiology • Acute hypervolaemic haemodilution • Permissive hypotension • Medical treatments, such as uterotonics for uterine bleeding 	<p>Maximize oxygen delivery</p> <ul style="list-style-type: none"> • Supplemental O₂ • Treat underlying lung pathology <p>Consider the following:</p> <ul style="list-style-type: none"> • Intubation/ventilation • Cardiopulmonary bypass, extracorporeal membrane oxygenation, or hyperbaric therapy • Red cell substitutes <p>Minimize O₂ uptake and metabolic demand</p> <ul style="list-style-type: none"> • Treat shock and maintain cardiac output <p>Consider the following:</p> <ul style="list-style-type: none"> • Sedation • Paralysis • Cooling 	<ul style="list-style-type: none"> • Iron sucrose 200 mg i.v. three times per week • Vitamin B₁₂ 1 mg i.v. once daily • Folate 20 mg i.v. on alternate days • Recombinant erythropoietin 600 µg kg⁻¹ (regimens vary; can be up to daily) 	<ul style="list-style-type: none"> • Maintain normothermia and stop drugs that impair clotting • Discuss with consultant haematologist • Cryoprecipitate (if acceptable) one pack per 10 kg body weight • Prothrombin complex concentrate 20–50 µg kg⁻¹ • Vitamin K 10 mg i.v. • Tranexamic acid 1 g i.v. every 6 h • Desmopressin 0.3 µg kg⁻¹ in 50 ml saline over 30 min <p>Consider the following:</p> <ul style="list-style-type: none"> • Fibrinogen concentrate (if acceptable) 2 g i.v. • Factor VIII and IX replacement • Recombinant factor VIIa 40–65 µg kg⁻¹ • Aprotinin

and obstetric patients^{52 53} by compressing the abdomen and lower limbs, thereby increasing peripheral vascular resistance resulting in proximal autotransfusion.⁵⁴ Their use is largely limited to low-resource settings.⁵⁵

- (iii) **Tamponade balloons** (e.g. the oesophageal **Sengstaken-Blakemore** tube or **intrauterine Bakri** balloon) may be appropriate depending on the anatomical location of bleeding.⁵⁶

Perioperative cell salvage

In this intervention, any blood lost is suctioned, anticoagulated, collected, centrifuged, washed, and later reinfused. Its use in elective and emergency scenarios is well established and has provided a safe and cost-effective alternative to allogeneic blood transfusion.⁵⁷ There are numerous case reports across a wide variety of surgical specialties of the successful use of cell salvage in Jehovah's Witnesses.^{58–60} It is worth clarifying whether Jehovah's Witnesses may also accept postoperative cell salvage of blood collected from drains.⁶¹ While many Jehovah's Witnesses may request that blood remains in continuity with their circulation,⁶² this is not always the case and may need to be assessed on a **patient-by-patient basis**.

Radiological care

Depending on the source of bleeding, interventional radiology can take several forms, including **embolization** and the insertion of intravascular occlusive balloons.⁶³ Such balloons have been used to limit bleeding in patients, including Jehovah's Witnesses,⁶⁴ in a variety of surgical settings where massive blood loss is a possibility.

Optimization of anaemia tolerance

In addition to the general measures that can be employed to optimize oxygen delivery and consumption (such as supplemental oxygen, intubation, and ventilation), some specific measures are as follows.

Deliberate hypothermia

Mild to moderate hypothermia has been used successfully in Jehovah's Witness patients (in conjunction with other therapies)^{65–67} by reducing total body oxygen **consumption** and **increasing** the **dissolved** portion of **oxygen** without impairing oxygen extraction.^{68 69} however, temperatures **below 35°C** have been shown to **increase blood loss** and transfusion requirements.⁷⁰

Extracorporeal oxygen therapies

Extracorporeal membrane oxygenation and cardiopulmonary bypass act as a means of providing circulatory (flow) and respiratory support (gaseous exchange). Their successful use has been described in Jehovah's Witnesses, although these have tended to be in elective surgery or in patients with respiratory failure and acceptable haemoglobin.^{71 72} Use in the critically ill and severely anaemic Jehovah's Witness has not been fully established.

Hyperbaric oxygen therapy

Hyperbaric oxygen therapy remains a treatment option in patients with profound hypoxia, and its successful intermittent use during a patient episode has been described in severely anaemic Jehovah's Witnesses.⁷³ In addition to the limited number

of sites, hyperbaric oxygen therapy presents other problems, the main one being the **logistics of transferring** a critically ill patient between critical care units and the chamber. Other problems include organization; most hyperbaric oxygen therapy centres are not adequately set up to deal with critically ill patients, and the intervention itself is not entirely benign.⁷⁴

Red cell substitutes

The WTS literature calls these 'a potential quality alternative to blood transfusion';⁷⁵ nevertheless, there are very few clinical cases outlining their application, and current research targets are for use in haemorrhagic shock or ischaemic stroke.⁷⁶ While UK use has declined, some may be available on **'compassionate grounds'**. Two main classes exist, namely the **haemoglobin-based oxygen carriers** and perfluorocarbons (PFCs).

Haemoglobin-based oxygen carriers deliver oxygen by **facilitated diffusion** using **human or bovine haemoglobin** (possibly acceptable to Jehovah's Witnesses). Currently, only Hemopure^{®77} is in clinical use (in South Africa), although Hemospan[®] (MP4) may receive a 2014 UK market launch.⁷⁸ Concerns regarding use include the expense, **profound vasoconstriction (NO scavenging)**, and an association with myocardial infarction and death in clinical trials.⁷⁹

Perfluorocarbons are liquid perfluorocarbons, emulsified with a phospholipid surfactant suspended in saline, that **dissolve** large amounts of **oxygen**. They are chemically inert and totally artificial. Fluosol-DA[®] and Fluosol-43[®] were previously available in the UK, but production ceased after difficulties with storage and use (**immunosuppression** and **lack of oncotic** properties with 1:1 blood loss substitution).⁸⁰ Currently, only Perftoran[®] is in use in the **Russian Federation**⁸¹ and **Mexico**.⁸²

Other novel agents are currently in preclinical trials, including dendrimers and porphyrin-based oxygen carriers.⁸³

Enhancement of haemoglobin concentration and red blood cell production

Anaemia is usually caused by one of three processes: acute blood loss, decreased or faulty red cell production, or red cell destruction. Anaemia is a risk factor for increased morbidity and mortality in a variety of patient types.^{84–86} When seen before surgery, it is a predictor for allogeneic transfusion.⁸⁷ In the context of capacity, some studies purport that **even mild anaemia** may be independently **associated** with impaired **cognition in the elderly**.⁸⁸ Although one small study of medical students showed that lower Hb concentrations were associated with lower mini-mental state examination scores, the effects in the rest of the population at large or the concept of a critical Hb concentration for sound cognition have not been investigated or confirmed.⁸⁹

Anaemia tolerance is a key principle in managing low Hb in Jehovah's Witnesses. Weiskopf and colleagues⁹⁰ and the TRICC trial⁹¹ established that in healthy volunteers, a reduction in Hb concentration from 131 to **70 g litre⁻¹** can be **tolerated** without a detrimental effect on oxygen transport. The level of anaemia that a patient will tolerate varies depending on the clinical practitioner and the setting (elective or emergent, preoperative or postoperative). Measures to reduce oxygen consumption or maximize oxygen delivery (Tables 3 and 4) increase tolerance to anaemia. Several reviews suggest that mortality as a result of lack of blood is a relatively uncommon event in Jehovah's Witnesses, as is anaemia-related death. However, Hb concentrations **below 50 g litre⁻¹** are **associated** with a **drastic increase** in **mortality**,⁹² and while survival^{93 94} has been reported with Hb concentrations

Table 4 I.V. iron preparations

Preparation	Ferric carboxymaltose	Ferumoxylol	Iron dextran	Iron sucrose	Iron isomaltoside 1000
Trade name	Ferinject®	Rienso® or Ferraheme®	CosmoFer®	Venofer®	Monofer®
Concentration (mg ml ⁻¹)	50	30	50	20	100
Test dose required	No	No	Yes (25 mg over 2 min)	No	No
Maximal single dose	1000 mg (up to 20 mg kg ⁻¹) Consult literature if <35 kg	510 mg A second 510 mg dose can be given 2–8 days later)	200 mg	200 mg	Bolus 500 mg up to three times per week
Administration rate	Up to 200 mg; no prescribed administration time 200–500 mg=100 mg min ⁻¹ >500 mg=over 15 min	1 ml s ⁻¹ (30 mg s ⁻¹)	Bolus 0.2 ml min ⁻¹ Preferably diluted in 10–20 ml	Bolus 1 ml min ⁻¹ Infusion 100 mg over at least 15 min	Infusion 20 mg kg ⁻¹ Bolus 50 mg min ⁻¹ Infusion up to 1000 mg over 30 min >1000 mg over 60 min
Diluent	0.9% NaCl	None	0.9% NaCl or 5% dextrose	0.9% NaCl	0.9% NaCl
Total dose infusion possible	Yes	No	Yes	No	Yes

as low as 14 g litre⁻¹, Spence and colleagues⁹⁵ demonstrated that below 50 g litre⁻¹, Hb concentration becomes an independent predictor of mortality.

In either instance (preoperative or postoperative), haemoglobin synthesis and erythropoiesis are intrinsically linked, and erythropoiesis-stimulating agents and the key substrates (iron, vitamin B₁₂, and folate) must be co-administered in order to work effectively.⁹⁶

Iron, vitamin B₁₂, and folate

Before surgery, either oral or i.v. iron can be used; however, i.v. iron produces a more rapid and reliable increase in Hb concentrations.⁹⁷ This is especially true in inflammatory states, where hepcidin (the hormone responsible for iron homeostasis) inhibits gut iron uptake and mobilization from storage sites.⁹⁸ Parenteral iron preparations consist of iron and chemically modified carbohydrates. We outline commonly used agents in Table 4. The effect of i.v. iron on erythropoiesis may only last up to 10 days,⁹⁷ and patients may require repeated doses for preoperative optimization. Despite many studies demonstrating its safety in a variety of clinical scenarios, there are still concerns regarding the relatively low incidence of severe hypersensitivity reactions.⁹⁹ Vitamin B₁₂ and folate should also be replaced if a preoperative deficiency is identified.

After surgery, the inflammatory component of the surgical stress response induces ferritin synthesis (regardless of total body iron stores)¹⁰⁰ and reduces transferrin and serum iron concentrations. These actions will reduce oral iron absorption; hence i.v. iron is the preferred option. Vitamin B₁₂ and folate are innocuous agents, and while there is little evidence to suggest significant benefit in the acute setting, the potential benefits are likely to outweigh any potential risk of administration.

Recombinant erythropoietin

Recombinant erythropoietin is the most frequently used erythropoiesis-stimulating agent. It was first used in the treatment of anaemia secondary to end-stage renal disease.¹⁰¹ Recombinant erythropoietin acts by stimulating the following: (i) proliferation and differentiation of erythroid precursors to increase immature erythrocyte production; (ii) release of erythrocytes from bone marrow; and (iii) Hb production.¹⁰² It may also protect cells by inhibiting various protein kinase cascades while increasing stem cell recruitment into damaged areas,¹⁰³ and has platelet-activating effects. The effects of recombinant erythropoietins are partly governed by ferritin, transferrin, iron, vitamin B₁₂, and folic acid concentrations.¹⁰⁴

Before surgery, it is important to check which recombinant erythropoietin preparation is being used because some do contain trace amounts of human albumin,¹⁰² which may conflict with the beliefs of some Jehovah's Witnesses. The response appears to be dose dependent,^{105 106} with an increase in reticulocyte count¹⁰⁷ being seen within 10 days and new erythropoiesis within 1–6 weeks.¹⁰¹ Preoperative regimens are either a single dose of 300 µg (at an approximate cost of £180 per dose) or multi-dose regimens, with a number of studies having used as much as 600 µg kg⁻¹ weekly for 3–4 weeks.¹⁰⁷

After surgery, there is a transient erythropoietin deficiency, which prevents an immediate response in erythrocyte production.¹⁰⁰ Postoperative regimens shown to be successful are also variable, including the following: (i) 600 µg kg⁻¹ daily for 7 days;¹⁰⁶ (ii) 600 µg kg⁻¹ every other day;⁵⁸ and (iii) giving 600 µg kg⁻¹ at 24 and 48 h after injury or surgery, followed by three

doses of 300 µg kg⁻¹ on days 3, 4, and 5, respectively.¹⁰⁸ A systematic review for the International Study of Perioperative Transfusion (ISPOT) group and other studies have shown an increase in Hb concentration and reduction in allogeneic transfusion with both the pre- and postoperative use of recombinant erythropoietin.^{109 110}

Correction of coagulation defects and promotion of haemostasis

The treatment of coagulopathy and promotion of haemostasis largely depend on whether the setting is elective or emergent. In both cases, therapy should be guided by coagulation tests (laboratory based or ideally point of care, e.g. thromboelastography (TEG) or thromboelastometry (ROTEM)), and early discussion with a haematologist is warranted both before and after surgery. While management in the elective setting can be more considered, the acute setting requires an aggressive and comprehensive strategy, with replacement of multiple elements simultaneously rather than piecemeal.

Before surgery, the first management step is to stop any drugs (e.g. non-steroidal anti-inflammatory drugs or oral anticoagulants) or herbal remedies (e.g. garlic or ginger) that may impair clotting and administer an antidote if appropriate. Any subsequent management depends on the detection of a preoperative abnormality, be it congenital or acquired. Electively, the most commonly used agents are those to correct an inherited coagulopathy and involve either stimulating factor release or production or replacing the factors themselves (it should be noted that any of these agents can or may also be used during or after surgery or in the emergent setting).

Desmopressin is a synthetic analogue of vasopressin. It improves haemostasis by stimulating hepatic release of clotting factor VIII¹¹¹ and endothelial release of tissue plasminogen activator and von Willebrand factor.^{112–114} Some papers suggest a preoperative test dose of 0.3 µg kg⁻¹ as an infusion over 30–45 min to ascertain patient response.¹¹⁵ While several papers have suggested a beneficial effect in Jehovah's Witness patients, a 2004 Cochrane review states that while desmopressin limits perioperative blood loss, the extent is not clinically important and only supports use in patients with inherited bleeding disorders.¹¹⁶

Specific clotting factors can be replaced individually. Recombinant factor VIII and IX concentrates may have a role in patients who refuse cryoprecipitate or fresh frozen plasma. Bolliger and colleagues¹¹⁷ described their use, with other agents, in Jehovah's Witnesses, with improved clot formation and platelet activation. Recombinant factor VIIa improves thrombin generation after vascular injury and may also inhibit fibrinolysis by activating thrombin-activatable fibrinolysis inhibitor.¹¹⁸ It is produced without human blood or plasma and is usually acceptable to Jehovah's Witnesses. It is licensed for use in patients with haemophilia and antibody inhibitors against factors VIII and IX and is an expensive treatment. The optimal dose has not been described, but a commonly used regimen in the literature is 40–65 µg kg⁻¹, repeated after 15–30 min if there is no improvement.⁵⁹ Its successful use has been shown in different haemorrhage scenarios, such as cardiac surgery,¹¹⁹ postpartum haemorrhage,¹²⁰ and intestinal bleeding;¹²¹ however, these are off-label prescriptions. Increasing evidence suggests that it does not improve long-term outcomes and may increase the thromboembolic event rate.¹²²

Another common preoperative scenario is antagonism of anticoagulant drugs, such as warfarin. Vitamin K is essential for the production of clotting factors II, VII, IX, and X and proteins C, S, and Z.¹²³ Vitamin K can be administered enterally or i.v.¹²⁴

While the i.v. route is associated with faster correction of international normalized ratio (4–8 h) vs oral (up to 24 h), care is advised because it may cause severe anaphylactoid reactions. It should be administered as a slow i.v. infusion of 10 mg over 20–60 min (which can be repeated after 12 h if required).¹²⁵

Vitamin K-dependent coagulation factors II, VII, IX, and X can be replaced by the use of Beriplex®. Its role in the antagonism of warfarin excess is well known.^{126 127} The initial bolus dose depends on international normalized ratio and is given with vitamin K. There are several case reports outlining its successful use in Jehovah's Witnesses¹²⁸ with a single bolus of 20 IU kg⁻¹ over 15 min. While both agents are plasma derived, Octaplex® (unlike Beriplex®) does not contain human albumin and may be more acceptable to Jehovah's Witnesses.¹²⁹

During and after surgery, the primary concern is arrest of bleeding and clot maintenance. Various studies have shown that aggressive fibrinogen replacement can result in faster, stronger, and better clot formation.¹³⁰ The first-line agent is cryoprecipitate, a plasma fraction rich in fibrinogen, von Willebrand Factor, and factor VIII. As it is a minor blood fraction, it may not be acceptable to some Jehovah's Witnesses. The usual dose is 1–2 units per 10 kg body weight or two pools (equivalent to 10 units), which will usually increase fibrinogen concentrations by 1 g litre⁻¹.^{131 132} While cryoprecipitate has been used in several Jehovah's Witness patient case reports (mostly patients undergoing cardiac surgery),¹³³ in none is it the sole agent used, which makes it difficult to appraise its individual effect. The second-line treatment is fibrinogen concentrate (which may be deemed unacceptable because it is derived from human plasma). Although not currently licensed in the UK, its use is associated with significantly reduced red cell loss and fresh frozen plasma and platelet use,¹³⁴ and in massive obstetric haemorrhage an observational study found it to be as efficacious as cryoprecipitate.¹³⁵ However, again, there is a paucity of evidence for its individual use in coagulopathy treatment in Jehovah's Witnesses. An initial dose of 1–2 g of fibrinogen concentrate is recommended.¹³⁶

Inhibition of fibrinolysis also improves clot formation. Lysine analogues act by binding to fibrin clots and competitively inhibiting plasminogen activation. Tranexamic acid is the agent of choice and is 10 times more potent than ε-aminocaproic acid. Prophylactic and emergency use of tranexamic acid^{137 138} is well recognized in many major haemorrhage protocols in Jehovah's Witnesses. Doses of 500–1000 mg i.v. or 10 mg kg⁻¹ every 6 h to a maximal rate of 100 mg min⁻¹ have been shown to be effective.¹³⁸

Aprotinin, a direct plasmin inhibitor, also inhibits fibrinolysis and has been used in a variety of surgical specialties,^{139 140} not limited to Jehovah's Witness patients. In 2008, the BART study¹⁴¹ suggested that use was associated with increased mortality. However, the European Medicines Agency's committee for medicinal products for human use recently stated that these findings were unreliable and recommended lifting suspension and, as such, it could be used on a named patient basis.¹⁴²

Summary

Treatment of Jehovah's Witnesses during the past 50 yr has led to a greater awareness of blood conservation and advances in bloodless surgery. Their beliefs regarding blood and transfusion raise various ethical and legal points, knowledge of which is essential. Evidence suggests that while there is no universally applicable treatment strategy, successful care requires a holistic approach focusing on pre-optimization, referral to an appropriate

environment for surgery, and perioperative blood-conservation techniques.

Declaration of interest

None declared.

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