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National Guidance on the Safe Administration of Intrathecal Chemotherapy

National guidance on the safe administration of intrathecal chemotherapy was issued on 6 November 2001 following the publication in April of two reports on intrathecal errors. By 31 December 2001 all Trusts where intrathecal chemotherapy is administered were required to be fully compliant with "*National Guidance on the Safe Administration of Intrathecal Chemotherapy*". Implementation of the national guidance will be monitored by the Chief Medical Officer.

Since 1985 there have been 13 recorded cases of patient death or paralysis as a result of the intrathecal rather than intravenous administration of Vincristine. In future no patients should die or be paralysed by maladministered spinal injections.

The guidance is available on:
www.doh.gov.uk/publications/coinh.html or
www.doh.gov.uk/intrathecalchemotherapy/index.htm

Further information from Dr Maura Briscoe, Senior Medical Officer, DHSSPS. Tel: 028 9052 0724 or e-mail: maura.briscoe@dhsspsni.gov.uk

Hyponatraemia

Guidance on the prevention of hyponatraemia in children will be issued soon. It has been prepared by a multidisciplinary group in response to an identified need for clear advice for staff who care for children in hospital.

Hyponatraemia is potentially extremely serious, a rapid fall in sodium leading to cerebral oedema, seizures and death. Any child on IV fluids or oral rehydration is potentially at risk.

Hyponatraemia most often reflects failure to excrete fluids. Stress, pain and nausea all stimulate antidiuretic hormone (ADH), which inhibits water excretion. Consequently post-operative patients and sick children are at particular risk.

The guidance provides clear and concise advice for medical and nursing staff on the baseline assessment required before prescribed fluids are started, and the essential measures that require monitoring. Rigorous monitoring of fluid balance and serum sodium in all children receiving prescribed fluids will help ensure that hyponatraemia and its consequences are prevented. The guidance does not consider the choice of fluid in detail, rather it is designed to complement fluid protocols in individual paediatric units.

The guidance will be issued to acute Trusts and will also be available on the Departmental website at www.dhsspsni.gov.

Further information can be obtained from Dr Miriam McCartney, Senior Medical Officer, DHSSPS. Tel: 028 9052 0744 or e-mail Miriam.mccarthy@dhsspsni.gov.uk.

Better Use of Blood in Northern Ireland

Blood and blood products save lives and provide clinical benefit to many patients. However, there is an increasing awareness of the need to use blood only when it is essential to do so.

CREST published Guidelines for Blood Transfusion Practice in Northern Ireland in February 2001. These included guidelines for red cell transfusion, the management of massive haemorrhage and use of blood components in obstetrics and neonatal transfusion. These were issued widely at the time of publication.

Clinical Guidelines on Perioperative Blood Transfusion for Elective Surgery have also been published by the Scottish Intercollegiate Guidelines Network (SIGN) in October 2001. These include recommendations on deciding whether or not to transfuse, reducing the risks of allogeneic blood transfusion, blood sparing strategies and blood use in cardiac and orthopaedic surgery. Guidance on implementation and audit of the guidelines is also included. Recommendations are graded A, B, C and D to indicate the strength of the supporting evidence.

Both these sets of guidelines are of relevance to Northern Ireland practitioners who use blood.

Crest Guidelines are available from Ms. Angela Lowry, CREST Secretariat, Room 517, Dundonald House, Upper Newtownards Road, Belfast and on the CREST website: . www.n-i.nhs.uk/crest

SIGN guidelinesare available on the SIGN website: www.sign.ac.uk./

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