

FROM THE INSIDE

No blood transfusion for my own anaemia—tit for tat?



Thomas Bein*

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I am an anaesthetist and intensivist, currently in retirement. I was the former head of Operative Intensive Care of the University Hospital Regensburg, Germany. In 30 years of clinical work, I took countless decisions of blood transfusions in critically ill patients suffering from anaemia, I discussed ‘thresholds’ for transfusion with colleagues, and—in general—became increasingly strict in respect of indications over the years. In 2015, at the age of 62 years, the diagnosis of a multiple myeloma kicked me out of work on account of leukopenia (0.67/nl); it propelled me into an oncologic career with numerous chemotherapies, ending in a high-dose chemotherapy and stem cell transplantation. Surviving this difficult procedure, I had six pleasant and eventful years with my wife, my children, my grandchildren, and many friends, despite the necessity of regular tumour-lab controls every 3 months. But it happened the way it had to: a recurrence occurred, and the start of new therapy cycles was unavoidable. Although under three cycles of daratumumab (monoclonal antibody), carfilzomib (selective proteasome inhibitor), and high-dose dexamethasone, the tumour marker dropped down markedly, and platelets and white cells stabilised, a progressive fall in the circulating concentration of hemoglobin (Hb) was noticeable.

With a value of Hb of 10.5 g/l, we were not worried, my oncologists and me—but I did notice I became a bit breathless after walking rapidly or dragging beer crates home. In the next controls, my Hb dropped further to 8.5 g/l. The hypothesis was—after exclusion of all other reasons (iron or folic acid deficiency, haemolysis, etc.) the ‘toxic’ side effects of daratumumab. Oncologists insisted on continuing therapy, and said, ‘You have to be patient’. Now, several problems manifested. A breathing

frequency of 30/min whilst at rest. Interrupted speaking as I had to catch my breath frequently. I used to be a fit dog owner, and Levie, my male Magyar Vizsla, was always happy to walk fast or jog with me. All over now: slow walking and gasping up a hill, interruptions like a *claudicatio intermittens*. Tachycardia up to 140/min under moderate exercise. And fatigue overcame me: in the afternoon, I began to feel pleased to go to bed early, and enjoy a good night’s rest.

Step by step, I became depressed, and my strong self-perception and my body scheme became shaky. Manifest fears of cardiac events, unexpected dizziness, episodes of sudden syncopes, or bouts of depression were added to my general condition and made me insecure. In other words, I was not the same anymore—even under ‘normal’ cancer conditions. I began to crave for a *nice*, red, packed blood bag, full of lovely, active erythrocytes waiting to restore my cells with fresh oxygen. Like a vampire, I dreamed of a bag in a vital red colour, infusing my port, but my oncologists said ‘No’—as long as my Hb value was greater than 8 g/l. Tit for tat? And—remembering my active career—a ‘threshold’ of 8 g/l was (except for some specific indications, for example, in cardiac surgery)—our goal for a ‘normal’ intensive care unit (ICU) patient in a posttraumatic condition, or who had undergone a big visceral surgery.

From my personal experience and from my personal applied and physically and psychically sensed anaemia, I ask: Are we intensivists too strict in our indications? Without doubt, physicians must act always in reflection of the balance of benefit and harm in every individual patient and in every single situation. Blood transfusions may cause harm: allergic reactions, fever, acute immune haemolytic reactions, and blood-borne infections. Although the frequency of these risks has been reduced markedly in recent years, they still exist, and every decision to transfuse should be taken carefully. As for me: I

*Correspondence: thomas.bein@ukr.de
Former Head of the Operative Intensive Care Unit, University Hospital Regensburg, Regensburg, Germany

am sure that the longer my anaemia persists at this level, as more willingly I will be ready for a transfusion—here or there—despite the well-known risks (I am only too well aware). The strong wish to be a normal and strong person again, happy and active, satisfactorily leading daily life activities, walking fast with the dog—this wish is overpowering, and might be a bit irrational for a chronically ill cancer patient. And, furthermore my position is not the same as a patient in the ICU, maybe largely in bed and trying to mobilise and recover. I wonder, if I were to go back to clinical practice now, would I be more ‘liberal’ in transfusion decisions? I think: yes!

As a good and responsible ICU doctor, I was very strict, and based many of my decisions on evidence, such as those to transfuse blood. That value relates to ‘no gain in mortality or length of stay,’ but should we focus in future studies more on patient-reported outcomes such as quality of life in daily activities? As a person, afflicted by cancer and affected by anaemia, a complete role change has occurred—from a doctor to a poor patient, a poor guy. Sometimes the experience of being a patient-poor guy would be wholesome, perhaps, for some doctors to understand their patients better. To preclude any misunderstanding: I do not say that you can only become a good doctor by experiencing severe illness. But to listen to the story of a doctor—patient with a long and extensive cancer career could initiate reflections and discourses for satisfactory patient–physician activity levels and communications.

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