## GUIDELINES FOR MANAGEMENT OF ASPLENIC PATIENTS

<table>
<thead>
<tr>
<th>Name of Author</th>
<th>Infection Prevention and Control Team</th>
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<tbody>
<tr>
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**WARNING:** Always ensure that you are using the most up to date policy or procedure document. If you are unsure, you can check that it is the most up to date version by looking on the Trust Website: [www.dbh.nhs.uk](http://www.dbh.nhs.uk) under the headings → ‘Freedom of Information’ → ‘Information Classes’ → ‘Policies and Procedures’
GUIDELINES FOR MANAGEMENT OF ASPLENIC PATIENTS

Amendment Form

Please record brief details of the changes made alongside the next version number.

If the APD has been reviewed without change, this information will still need to be recorded although the version number will remain the same.

<table>
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<tr>
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<th>Author</th>
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<tr>
<td>Version 3</td>
<td>March 2009</td>
<td>• Amendment form and contents page added&lt;br&gt;• A section on ‘Duties’ and ‘Education and Training’ added&lt;br&gt;• Updated item 5 - Action to be Taken and item 6 - Antibiotics - please read in full&lt;br&gt;• Sections numbered&lt;br&gt;• References updated</td>
<td>Infection Prevention and Control Team</td>
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# GUIDELINES FOR MANAGEMENT OF ASPLENIC PATIENTS

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GUIDELINES FOR MANAGEMENT OF ASPLENIC PATIENTS

1. INTRODUCTION

People with an absent or dysfunctional spleen are at increased risk of severe infection. The risk is greater in the first 2 years following splenectomy, but persists throughout life. The commonest infection is Streptococcus pneumoniae, but other organisms also present significant risks, e.g. Haemophilus influenzae type b (Hib) and Neisseria Meningitidis.

In January 1994, the Chief Medical Officer of the Department of Health wrote to all doctors regarding the consequences of splenectomy1. Further advice was issued in March 20012 and advice on vaccinations can be found in the “Green Book”5. The British Society of Haematology has also issued guidance6.

2. AIM OF POLICY

To ensure that asplenic/hyposplenic patients are optimally managed to prevent infections to which they are particularly susceptible.

3. DUTIES

This policy covers infection prevention and control management issues and applies to all health care workers employed by the Trust that undertake patient care, or who may come into contact with affected patients.

Trust staff this includes:-
- Employees
- Agency/Locum/Bank Staff/Students
- Visiting/honorary consultant/clinicians
- Contractors whilst working on the Trust premises
- Volunteers

Each individual member of staff, volunteer or contracted worker within the Trust is responsible for complying with the standards set out in the Policy. They need to be aware of their personal responsibilities in preventing the spread of infection. It is the responsibility of Divisional Directors and Managers to ensure compliance with this standard.

4. EDUCATION AND TRAINING

Staff will receive instructions and direction regarding infection prevention and control practice and information from a number of sources:-
- Trust Induction
- Trust Policies and Procedures available on the intranet
- Ward/departmental/line managers
- As part of the mandatory infection control education update sessions which can be delivered by a number of formats e.g. face to face and e learning
- Infection Prevention and Control Educational displays/ posters
- Trust Infection Prevention and Control Team
The training delivered by the IPC team to educate staff who screen, treat and care for patients, will include, guidance on documentation at all appropriate points is the patient journey. Infection prevention and control must be included in individual Annual Professional Development Appraisal and any training needs for infection prevention and control addressed.

5. **ACTION TO BE TAKEN**

The following procedures should be followed for all asplenic/hyposplenic patients:

5.1 The medical records should be clearly marked including the alert sheet in the case notes highlighting asplenic status and the patient should carry a card or wear a bracelet/necklet stating the risk of infection.

5.2 **VACCINATION.** This should take place at least 2 weeks before elective splenectomy (optimum 4-6 weeks). In the case of emergency splenectomy, vaccination is most efficacious if given at least 14 days after surgery. If the patient leaves hospital before this time, then vaccinations should be given before discharge.

The following is recommended:

5.2.1 **Pneumococcal vaccine (23-valent polysaccharide vaccine).** A single injection (0.5 ml SC or IM), with boosters at 5 year intervals.

Children under 2 years cannot have the polysaccharide vaccine due to lack of efficacy at this age and should have the new conjugate pneumococcal vaccine\(^3\)\(^4\). Doses should be as follows in previously unvaccinated children:

- **6 months old or less:** three doses, each of 0.5ml, the first dose usually given at 2 months of age and with an interval of at least 1 month between doses. A fourth dose is recommended in the second year of life.

**Previously unvaccinated older infants and children:**

- **7–11 months:** two doses, each of 0.5ml, with an interval of at least one-month between doses. A third dose is recommended in the second year of life.

- **12–23 months:** two doses, each of 0.5ml, with an interval of at least 2 months between doses.

After their 2\(^{nd}\) birthday, they should receive a single dose of 23-valent pneumococcal **polysaccharide** vaccine (at least 1 month should be left between the conjugate vaccine and the polysaccharide vaccine).

5.2.2 **Hib (Haemophilus influenzae type b) vaccine** - Individuals aged ten years or over who have been fully immunised as part of the routine programme, should be offered one dose (usually as combined Hib/MenC vaccine, at the same time
as pneumococcal immunisation). Individuals aged ten years or over who have not been fully immunised should receive two doses, two months apart. Children under ten years of age should be vaccinated according to the routine programme.

5.2.3 **Meningococcal C conjugate vaccine.** Children and adults who have been fully immunised as part of the routine programme, should be offered one dose (usually as combined Hib/MenC vaccine, at the same time as pneumococcal immunisation). Children over one year of age and adults who have not been fully immunised should be given two doses, two months apart. Children under one year should be vaccinated according to the routine programme.

5.2.4 **Influenza vaccine.** Should be given annually in the autumn.

See green book for further details

Other routine immunisations, including live vaccines, can be given as usual unless the patient is immunosuppressed.

6. **ANTIBIOTICS**

The first 2 years after splenectomy is the period of highest risk, but antibiotic prophylaxis is recommended for life. This is particularly important when there is impaired underlying immune function. Antibiotic of choice is penicillin V (phenoxyethylpenicillin).

**Note: Antibiotic prophylaxis if not fully reliable**

Recommended dosages:

<table>
<thead>
<tr>
<th>Adult phenoxyethylpenicillin</th>
<th>500 mg b.d*</th>
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<tbody>
<tr>
<td>Child 6-12 years</td>
<td>250 mg b.d</td>
</tr>
<tr>
<td>Child &lt;6 years</td>
<td>125 mg b.d</td>
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*If compliance is a problem then 500mg once daily is acceptable.

**Erythromycin should be used in penicillin-allergic patients.**

Recommended dosages:

<table>
<thead>
<tr>
<th>Adult &amp; Child &gt;8 years</th>
<th>500 mg o.d</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child 2-8 years</td>
<td>250 mg o.d</td>
</tr>
<tr>
<td>Child &lt;2 years</td>
<td>125 mg o.d</td>
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Patients may also be given a small supply of suitable antibiotic to begin immediately if they have a febrile illness. This is particularly important for patients who do not take long-term prophylaxis.
7. FOREIGN TRAVEL

Malaria poses more of a threat to people without a functioning spleen. The importance of taking anti-malarial prophylaxis and other precautions (insect repellents, correct clothing and mosquito screens at night) should be emphasised.

Asplenic/hyposplenic patients travelling to countries in which Group A meningococcal disease is the common type should be given meningococcal Groups A and C polysaccharide vaccine or quadrivalent (A, C, W, Y) vaccine.

8. OTHER MEASURES

Asplenic patients are particularly susceptible to infection following animal bites and insect bites and should be alerted to this, so that they attend promptly for appropriate management.

Capnocytophaga canimorsus may follow animal (particularly dog) bites. The infection responds to a five day course of co-amoxiclav (or erythromycin if penicillin-allergic).

Babesiosis is a rare tick borne infection which can affect asplenic patients following a tick bite.

“I have no functioning spleen” cards can be downloaded from the Department of Health website (www.dh.gov.uk). A patient information leaflet can also be downloaded from the same site.

9. REFERENCES:

1 Department of Health. Asplenic patients and immunisation. C.M.O.’s Update 1994; 1:3.


