Maternal anti-D prophylaxis during pregnancy does not cause neonatal haemolysis

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Abstract

Objective—To evaluate signs of haemolysis in babies of Rh-D negative mothers who underwent prophylaxis with anti-D immunoglobulin during pregnancy.

Design—The following were evaluated in all babies of Rh-D negative mothers born within a three month period in our department: haemoglobin level, packed cell volume, mean corpuscular volume, reticulocytes, bilirubin level, and direct Coombs’ test (direct anti-globulin test).

The babies were divided into two groups according to number of doses of anti-D immunoglobulin received by the mother (one or two), and then further divided by their Rh status (negative or positive).

Results—The study group consisted of 101 babies and the control group of 37 babies. No statistically significant differences were found for any of the haematological variables between the babies of mothers who received one or two doses of anti-D immunoglobulin, or between the Rh negative babies (n = 35), and the controls. Although 20% of the Rh positive babies born to mothers receiving two doses of anti-D immunoglobulin had a positive result in the direct Coombs’ test compared with only 2.4% of the babies of mothers treated with only one dose, no signs of haemolysis were documented in the babies with a positive Coombs test.

Conclusion—The prevention of Rh immunisation with anti-D immunoglobulin (one or two doses) during pregnancy does not jeopardise the newborn. Blood group typing and direct Coombs’ test should be performed in every newborn of an Rh negative mother to establish whether there is a necessity to administer anti-D. In the presence of a positive direct Coombs’ test, the type of antibodies should be identified.

Keywords: Rh incompatibility; anti-D prophylaxis; haemolysis; newborn

Rh disease occurs in Rh-D positive fetuses of Rh negative mothers who were immunised by transplacental passage of Rh-D positive fetal red blood cells during a previous pregnancy. In such cases, maternal IgG antibodies to Rh-D cross the placenta, coating and destroying the Rh-D positive fetal red blood cells. Until three decades ago, before the use of aggressive fetal and neonatal treatment, haemolytic disease of the newborn due to Rh incompatibility was a major cause of death from hydrops in 25% of affected fetuses and death from kernicterus in 25% of severely affected neonates. In 1968, Bowman reported that this disease was preventable by injection with Rh(D) immunoglobulin immediately after birth to Rh-D negative mothers who had given birth to an Rh-D positive infant. This treatment was later recommended at the McMaster Conference on Prevention of Rh Immunisation. A more recent statement on routine antenatal prophylaxis has been published in the United Kingdom. Unless the father is known to be Rh-D negative, the mother must receive RhO(D) immunoglobulin (at a dose of 500 IU), at 28 or 34 weeks gestation, and also after abortion, amniocentesis, chorionic villi sampling, or any other invasive intruterine procedure (cordocentesis, external version, maternal trauma, etc). According to Thornton et al, the effect of anti-D immunoglobulin injection persists at least into the second pregnancy. The increase in this practice has led to more pregnant women being exposed to two or more doses of anti-D immunoglobulin before delivery. Because anti-D antibodies can cross the placenta and raise fetal antibody titres, their injection increases the potential risk of haemolytic damage to RhD positive fetuses.

This problem has to date received little attention. The aim of this study was to evaluate markers of haemolysis in babies of RhD negative mothers given one or two doses of RhO(D) immunoglobulin.

Materials and methods

The study group included all babies born to Rh negative mothers at the Rabin Medical Center, Beilinson Campus, Petah Tiqva, Israel within a three month period (1 January to 31 March 1999). For each mother, number of previous pregnancies and births and number of doses of anti-D immunoglobulin received during the present pregnancy were recorded. For all babies, in addition to the routine blood group typing and Coombs’ test, blood smear was performed at age 12–36 hours, and haemoglobin, packed cell volume, mean corpuscular volume, percentage reticulocytes, and bilirubin level were recorded, as were gestational age and birth weight. The study was approved by the ethics committee at Rabin Medical Center, and all parents gave informed consent.

The infants were grouped according to the number of maternal doses of anti-D immunoglobulin: one (routine prophylaxis at 28
Prevention of Rh isooimmunisation during pregnancy

VALUES ARE MEANS (SD). THE STATISTICAL TEST USED WAS ANALYSIS OF VARIANCE USING THE DUNCAN MULTIPLE COMPARISON OPTION.
received two doses of anti-D immunoglobulin (group 2) compared with only one of the 41 infants (2%) whose mothers had received only one dose (group 1). In all infants with positive Coombs’ test, antibody identification disclosed only anti-D immunoglobulin. Although mean gestational age (38.5 weeks) and birth weight (2882 g) were lower in the babies with a positive Coombs test, mean packed cell volume (60.25%), mean haemoglobin (19.8 g/dl), percentage reticulocytes (4.4), and presence of neonatal jaundice were similar to the findings for the babies with a negative Coombs’ test.

Discussion
To the best of our knowledge, the fetal risk of haemolysis due to high maternal doses of anti-D immunoglobulin has hardly been explored. However, the current dose was extensively studied before clinical use. Hermann and Kjellman found no changes in cord packed cell volume or bilirubin concentration in 510 babies of mothers who had received a single dose of anti-D immunoglobulin during pregnancy. No prospective studies have evaluated haematological variables as signs of haemolysis in newborns of women treated with multiple doses.

Our study showed no significant differences, compared with controls, in haemoglobin, packed cell volume, or percentage reticulocytes in Rh positive babies born to Rh negative mothers who had received one or two doses of anti-D immunoglobulin. This was also true when the six babies of the 66 Rh negative mothers (9%) who had a positive direct Coombs’ test were analysed separately. Furthermore, even though there were significantly more positive direct Coombs’ tests among the babies of mothers who had received two doses of anti-D immunoglobulin (20%) than among babies whose mothers had received only one dose (2%), their haematological variables were similar. These findings indicate that the placental passage of anti-D immunoglobulin does not produce haematological changes relevant to haemolysis.

We therefore conclude that the prevention of Rh isoimmunisation by the injection of anti-D immunoglobulin, whether one or two doses, does not jeopardise newborns, even in the event of transplacental passage of anti-D immunoglobulin (9% of cases).

Our study supports the routine practice of blood group typing and direct Coombs’ testing in every baby of an Rh negative mother immediately after birth to establish the necessity to administer anti-D immunoglobulin. It does not support the practice of taking a blood count in these babies as a routine procedure. In the presence of a positive direct Coombs’ test, the antibodies need to be identified as Rh-D type to exclude the possibility of other minor blood group incompatibilities; of course, in this special situation, early jaundice and haematological signs of haemolysis will be present.

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