**Supplemental Table 1.** Society Recommendations for Neuraxial Procedures in the Setting of Thrombocytopenia

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| **Society Recommendations for Neuraxial Procedures in the Setting of Thrombocytopenia** |
| **Society and Year of Publication** | **Neuraxial Procedure Types** | **Indications to Assess Platelet Number Prior to Procedure** | **Platelet Count (x106/L) Recommendations** |
| **Anesthesiology Societies** |
| **American Society of Regional Anesthesiology and Pain Medicine (ASRA), 2018**[**1**](#_ENREF_1) | Anesthesia | If unfractionated heparin administered > 4 days, check plts prior to NB/CR | NA |
| **American Society of Anesthesiologists,****2016**[**2**](#_ENREF_2) | Obstetric anesthesia | Decision to check plts should be individualized and based on patient’s history, physical examination, and clinical signs. Routine plts not necessary in healthy parturient. | NA |
| **American Society of Regional Anesthesiology and Pain Medicine (ASRA), 2015**[**3**](#_ENREF_3) | Pain procedures | Check plts if glycoprotein IIb/IIIa receptor antagonist (abciximab, eptifibatide, tirofiban) administered | NA |
| **German Society for Anesthesiology and Intensive Care,****2014**[**4**](#_ENREF_4) | Anesthesia | For unfractionated heparin or LMWH administered for >5 days, check plts prior to NB/CR | NA |
| **Association of Anaesthetists of Great Britain and Ireland (AAGBI),****2013**[**5**](#_ENREF_5) | Obstetric anesthesia | **DIC:** incompatible with neuraxial anesthesia**Massive transfusion:** assessment of plt function should occur in patients who have been given plt transfusions prior to NB**Liver failure**: assessment of coagulopathy including plt number and function**Uremia**: assessment of plt number and function**Trauma**: coagulopathy should be assessed **Sepsis**: coagulopathy should be assessed | **Risk assessment for spinal hematoma in obstetric patients:****Normal risk**-Preeclampsia: **>100,000** within 6hrs of NB-ITP: **>75,000** within 24hrs of NB-IUFD: COAGS normal within 6hrs of block**Increased risk**-Preeclampsia:**75-100,000**-ITP: **50-75,000**-IUFD: no clinical tests and no COAGS available**High risk**-Preeclampsia:**75-100,000**(decreasing) and normal COAGS-ITP: **20-50,000****Very high risk**-Preeclampsia**: <75,000** or abnormal COAGS or HELLP syndrome-ITP: **<20,000** -IUFD: abruption or overt sepsis |
| **Sociedade Brasileira de Anestesiologia (SBA), 2013**[**6**](#_ENREF_6) | Anesthesia | If unfractionated heparin administered > 5 days, check plt prior to NB/CR | Epidural or spinal blocks, in the absence of risk factors for bleeding, may be performed with plts **>80,000** |
| **Belgium Association for Regional Anaesthesia (BARA),****2011**[**7**](#_ENREF_7) | Anesthesia | If unfractionated heparin or LMWH has been administered for 5 days (or greater), check plt prior to NB/CR.Check plt if glycoprotein IIb/IIIa receptor antagonist (abciximab, eptifibatide, tirofiban) administered | NA |
| **European Society of Anesthesiology (ESA), 2010**[**8**](#_ENREF_8) | Anesthesia | If unfractionated heparin administered >5 days, check plts prior to NB/CR.Check plts if glycoprotein IIb/IIIa receptor antagonist (abciximab, eptifibatide, tirofiban) administered | NA |
| **Scandinavian Society of Anesthesiology (SCA), 2010**[**9**](#_ENREF_9) | Anesthesia | For unfractionated heparin given >5 days, check plts prior to NB/CR**Liver failure**: NB contraindicated in severe hepatic dysfunction with elevated INR or plts **<100,000** | Acceptable counts of normally functioning plts depend on type of neuraxial block and indication:Single shot spinal anesthesia-Benefit comfort: **>100,000**-Benefit reduce morbidity: **>50,000**-Benefit reduce mortality: **>30,000**Epidural & CSE-Benefit comfort: **>100,000**-Benefit reduce morbidity: **>80,000**-Benefit reduce mortality: **>50,000** |
| **Transfusion Medicine Societies** |
| **American Red Cross,****2017**[**10**](#_ENREF_10) | Diagnostic LP | NA | Prophylactic plt transfusion recommended for plts **<20,000** |
| Anesthesia | NA | Prophylactic plt transfusion recommended if plts **<80,000** |
| **AABB (formerly, American Association of Blood Banks), 2015**[**11**](#_ENREF_11) | Diagnostic LP | NA | Prophylactic plt transfusion recommended for patients having elective diagnostic LP with plts **<50,000** |
| **The Dutch Institute of Healthcare Improvement (CBO),****2011**[**12**](#_ENREF_12) | LP | NA | Target value **>20,000** |
| Pediatric LP | NA | Plt count **>50,000** in ALL with blasts in peripheral bloodPlts **>10,000** in stable children with ALL without blasts |
| **Italian Society of Transfusion Medicine & Immunohaematology (SIMTI), 2011**[**13**](#_ENREF_13) | Anesthesia and LP | NA | Bring plts above **50,000** |
| **German Society of Transfusion Medicine,****2009**[**14**](#_ENREF_14) | Anesthesia | NA | Plt transfusion prior to epidural if plts **<80,000**; prior to spinal if plts **<50,000** |
| Diagnostic LP | NA | Plt transfusion prior to elective LP if plts **<50,000**For urgent diagnostic procedures plts of **20,000** sufficient unless symptoms of hemorrhage In patients with severe sepsis for whom LP necessary for diagnosis (e.g. meningococcal sepsis suspected), LP may be performed independent of plts. If plts **<10,000** plt transfusion should be performed |
| **French Safety Agency for Health Products (AFSSaPS),****2005**[**15**](#_ENREF_15) | Anesthesia | NA | Plts >**50,000** sufficient for spinal anesthesiaPlts >**80,000** sufficient for epidurals*-Other risk factors must be taken into account, as well as progressive nature of thrombocytopenia* |
| **Hematology and Oncology Societies** |
| **American Society of Clinical Oncology,****2018**[**16**](#_ENREF_16) | LP | NA | Plts of **40,000-50,000** sufficient to perform “major invasive procedures”  |
| **British Committee for Standards in Haematology,****2017**[**17**](#_ENREF_17) | LP | NA | Consider performing LP above the plt threshold of **40,000** |
| Insertion/removal of epidural catheter | NA | Consider performing epidural catheter insertion or removal above plt threshold of **80,000** |
| **British Committee for Standards in Haematology,****2016**[**18**](#_ENREF_18) | Pediatric LP | NA | Threshold for plt transfusion prior to LP is **<40,000** *It is accepted that prior to LP some clinicians will transfuse plts at higher counts (e.g.* ***50,000****) in unstable children, nonALL patients, or for first LP in newly diagnosed ALL to avoid haemorrhage and CSF contamination with blasts, or at lower counts (****≤20,000****) in stable patients with ALL, depending on clinical situation* |
| **British Society for Haematology,****2015**[**19**](#_ENREF_19) | Obstetric anesthesia in Acute Myeloid Leukemia | NA | Epidural anesthesia should be avoided in plts **<80,000** |

Plt = platelet; Plts = platelet count; COAGS = coagulation tests; NB= neuraxial block; CR = catheter removal; ITP = idiopathic thrombocytopenia purpura; NSAID = nonsteroidal anti-inflammatory drugs; ASA = aspirin; LMWH = low molecular weight heparin; LP = lumbar puncture; NA = Not discussed in guidelines, IUFD= intrauterine fetal demise; CSE = combined spinal epidural; ALL= acute lymphatic leukemia; LP = lumbar puncture; CSF = cerebrospinal fluid

**Supplemental Table 2**. Practitionersurveys assessing platelet cutoffs for performing neuraxial procedures

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| **Anesthesiologist Surveys:****Willingness to Perform Neuraxial Procedures in Thrombocytopenia in Pregnancy** |
| **Study** | **Number of responders** | **Patient population** | **Platelet count (106/L)** | **Percentage who *Would Perform* Procedure** |
| **Beilin**[**21**](#_ENREF_21)(1996) | N= 113 Academic practitionersN= 94 Private practitioners | *Otherwise healthy* | 100,000-150,000 | 100% Academic practitioners100% Private practitioners |
| 80,000-99,000 | 66% Academic practitioners55% Private practitioners |
| 50,000-79,000 | 16% Academic practitioners9% Private practitioners |
| <50,000 | 2% Academic practitioners0% Private practitioners  |
| **Wee**[**22**](#_ENREF_22)(2002) | N=213 Obstetric anesthesiologists | *Immune Thrombocytopenia* | >100,000 | 96% Epidural procedure96% Spinal procedure |
| 80,000-100,000 | 64% Epidural procedure74% Spinal procedure |
| 50,000-79,000 | 22% Epidural procedure31% Spinal procedure |
| <50,000 | 4% Epidural procedure9% Spinal procedure |
| After correction of platelet count | 76% Epidural procedure79% Spinal procedure |
|  | *Preeclampsia* | >100,000 | 98% Epidural procedure98% Spinal procedure |
|  | 80,000-100,000 | 72% Epidural procedure78% Spinal procedure |
| N= 224 Obstetric anesthesiologists | 50,000-79,000 | 22% Epidural procedure30% Spinal procedure |
|  | <50,000 | 4% Epidural procedure7% Spinal procedure |
|  | After correction of platelet count | 72% Epidural procedure74% Spinal procedure |
| **Breen**[**23**](#_ENREF_23) (2000) | N= 308 Community anesthesiologistsN= 204 University anesthesiologists | Not specified  | Would place epidural catheter at 50,000 | 14.6% Community anesthesiologists16.2% University anesthesiologists |
|  *Minimum platelet count you will accept and still provide epidural analgesia*  *Community anesthesiologists: 80,600 +/- 18,800 (n=308)* *University anesthesiologist: 79,500 +/- 18,000 (n= 204)* |
| **Staikou**[**24**](#_ENREF_24) (2014) | N= 341 | *Parturient with no signs or history of bleeding* | ***At which platelet count will you NOT consider regional analgesia or anesthesia*** |
| <100,000 | 21.4% |
| <80,000 | 60.4%  |
| <50,000 | 89.4% |

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