



Complete Summary

GUIDELINE TITLE

Routine antenatal anti-D prophylaxis for women who are rhesus D negative.

BIBLIOGRAPHIC SOURCE(S)

National Institute for Health and Clinical Excellence (NICE). Routine antenatal anti-D prophylaxis for women who are rhesus D negative. London (UK): National Institute for Health and Clinical Excellence (NICE); 2008 Aug. 27 p. (Technology appraisal guidance; no. 156).

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE
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SCOPE

DISEASE/CONDITION(S)

Pregnancy in rhesus D-negative women

GUIDELINE CATEGORY

Assessment of Therapeutic Effectiveness
Prevention

CLINICAL SPECIALTY

Obstetrics and Gynecology
Preventive Medicine

INTENDED USERS

Advanced Practice Nurses
Nurses
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

To evaluate the clinical effectiveness and cost-effectiveness of routine antenatal anti-D prophylaxis for women who are rhesus D (RhD) negative

TARGET POPULATION

Pregnant rhesus D (RhD)-negative women

INTERVENTIONS AND PRACTICES CONSIDERED

Routine antenatal anti-D prophylaxis with:

- D-Gam
- Partobulin SDF
- Rhophylac
- WinRho SDF

MAJOR OUTCOMES CONSIDERED

- Clinical effectiveness
 - Sensitization (alloimmunisation) rates among rhesus D (RhD)-negative women delivered of RhD-positive infants (the at-risk population)
 - Incidence of hemolytic disease of the newborn (HDN)
 - Survival of the child
 - Disability of the child
 - Health-related quality of life
 - Adverse effects of treatment
- Cost-effectiveness

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases
Searches of Unpublished Data

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): The National Institute for Health and Clinical Excellence (NICE) commissioned an independent

academic centre to perform a systematic literature review on the technology considered in this appraisal and prepare a Technology Assessment Report. The Technology Assessment Report for this technology appraisal was prepared by University of Sheffield, School of Health and Related Research (ScHARR) (see the "Availability of Companion Documents" field).

Clinical Effectiveness

Sources Searched

Keyword and thesauri searches were undertaken in Medline, CINAHL, Embase, BIOSIS, Science Citation Index, Cochrane Database of Systematic Reviews, Database of Abstracts of Reviews of Effects, Cochrane Central Register of Controlled Trials, National Health Service (NHS) Health Technology Assessment database and NHS Economic Evaluations Database. Websites containing registers of trials and ongoing research were also searched. These included the National Research Register and the MetaRegister of the Current Controlled Trials website. In addition, the bibliographies of retrieved papers (including the previous review) were scrutinised.

Keyword Strategies

Sensitive keyword strategies using free-text and, where available, thesaurus terms were developed to search the electronic databases. Synonyms relating to the intervention (e.g., Rh-Hr Blood-Group System, Rho(D) Immune Globulin, Rh Isoimmunisation and anti-d prophylaxis) were combined with synonyms relating to the patient population (e.g., pregnancy, pregnancy complications, pregnancy trimesters, prenatal care, postnatal care).

Search Restrictions

A methodological filter aimed at identifying controlled clinical trials (including before and after studies) was used in the searches of Medline, Embase and Cinahl. Further filters were used to identify papers relating to cost/s and systematic reviews. Language restrictions were not used on any database, and no date restrictions were applied. All searches were undertaken between May and August 2006.

A copy of the general search strategy may be found in Appendix 1 of the Assessment Report (see the "Availability of Companion Documents" field).

Specific systematic searches for adverse event data were not undertaken, and the clinical review therefore includes only adverse event data reported by the included studies.

Inclusion and Exclusion Criteria

Inclusion Criteria

Population: Pregnant women who are rhesus D (RhD)-negative

Intervention: Routine antenatal anti-D prophylaxis (RAADP) using *either* 2 doses of at least 500 international units (IU) at 28 and 34 weeks' gestation *or* a single dose of at least 1500 IU at 28 weeks' gestation, in either case followed, if the infant is RhD-positive, by a further dose of anti-D given at, or within 72 hours of, delivery.

Comparator

- RAADP using different dosing regimens and/or methods of administration
- No RAADP

Outcomes

- Sensitisation (alloimmunisation) rates among RhD-negative women delivered of RhD-positive infants (the at-risk population)
- Incidence of haemolytic disease of the newborn (HDN)
- Survival of the child
- Disability of the child
- Health-related quality of life
- Adverse effects of treatment

Study design: any of:

- Systematic reviews
- Randomised controlled trials
- Non-randomised controlled trials

Exclusion Criteria

Studies considered methodologically unsound, or not reporting results in the necessary detail.

Cost-Effectiveness

A systematic review of economic evaluations was carried out using the search criteria and databases set out for the clinical effectiveness (see above); the only variation from this being the study design criteria defined as economic evaluations.

NUMBER OF SOURCE DOCUMENTS

Clinical Effectiveness

Total full papers accepted: N=12 (relating to 8 studies of clinical effectiveness):

- 1 randomized controlled trial (RCT)
- 1 quasi-RCT
- 1 community intervention trial
- 1 retrospective before-and-after trial
- 5 nonrandomised studies with historical or geographical controls

Cost-Effectiveness

- Published literature: Total full papers accepted: N=11 (relating to 9 studies)
- An economic model presented by the Assessment Group was included in the review.

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Meta-Analysis
Review of Published Meta-Analyses
Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): The National Institute for Health and Clinical Excellence (NICE) commissioned an independent academic centre to perform a systematic literature review on the technology considered in this appraisal and prepare a Technology Assessment Report. The Technology Assessment Report for this technology appraisal was prepared by University of Sheffield, School of Health and Related Research (SchARR) (see the "Availability of Companion Documents" field).

Clinical Effectiveness

Data Abstraction Strategy

Data were abstracted by one researcher using a standardised data extraction form. Any studies which gave rise to uncertainty were reviewed by a second researcher and any disagreements resolved by discussion.

Critical Appraisal Strategy

Published papers were assessed according to the accepted hierarchy of evidence, whereby meta-analyses of randomised controlled trials are taken to be the most authoritative forms of evidence, with uncontrolled observational studies the least authoritative. Because of the paucity of randomised controlled trials in this area, data from non-randomised studies were also used. The quality of randomised studies was assessed using quality criteria based on those proposed by the National Health Service (NHS) Centre for Reviews and Dissemination (CRD) (refer to Appendix 2 of the Assessment Report [see the "Availability of Companion Documents" field]). However, the CRD quality criteria for observational studies were of very limited relevance to the specific non-randomised studies included in

this review, and their quality was therefore judged primarily on the basis of two key factors: the comparability of the intervention and control groups, and the use of intention-to-treat analysis.

Methods of Data Synthesis

The pre-specified outcomes have been tabulated and discussed within a descriptive synthesis. Where appropriate, meta-analysis has been used to synthesise data. The meta-analyses were conducted using binary logistic regression with a fixed effects model, using Minitab statistical software. The study and treatment group were used as the variables for the model. The outcome of the regression analysis was an odds ratio for the treatment arm versus the control arm. Because of the low event probability, the odds ratio was assumed to be a good approximation to the relative risk of sensitisation in the cohort who received routine antenatal anti-D prophylaxis (RAADP), compared with the relative risk of sensitisation in patients who received conventional management.

Cost-Effectiveness

Systematic Review of Existing Cost-Effectiveness Evidence

Owing to the variability between the studies, a quality assessment has not formally been carried out. However, an overview of the nine included economic evaluations is presented in Section 6.1 of the Assessment Report (see the "Availability of Companion Documents" field).

Independent Economic Assessment

Modelling Methodology and Scope

The model simulates the experience of a hypothetical cohort of women to whom national fertility rates are assumed to apply. The experience of this cohort over time is assumed to match the experience of a mixed population of primigravidae and multigravidae during any one year.

The outcomes of interest within the model are:

- Cost per sensitisation avoided
- Cost per affected pregnancy avoided
- Cost per foetal loss avoided
- Cost per life year gained (LYG)
- Cost per quality-adjusted life year (QALY) gained

Refer to Section 6.2 of the Assessment Report (see the "Availability of Companion Documents" field) for more information.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Considerations

Technology appraisal recommendations are based on a review of clinical and economic evidence.

Technology Appraisal Process

The National Institute for Health and Clinical Excellence (NICE) invites 'consultee' and 'commentator' organisations to take part in the appraisal process. Consultee organisations include national groups representing patients and carers, the bodies representing health professionals, and the manufacturers of the technology under review. Consultees are invited to submit evidence during the appraisal and to comment on the appraisal documents.

Commentator organisations include manufacturers of the products with which the technology is being compared, the National Health Service (NHS) Quality Improvement Scotland and research groups working in the area. They can comment on the evidence and other documents but are not asked to submit evidence themselves.

NICE then commissions an independent academic centre to review published evidence on the technology and prepare an 'assessment report'. Consultees and commentators are invited to comment on the report. The assessment report and the comments on it are then drawn together in a document called the evaluation report.

An independent Appraisal Committee then considers the evaluation report. It holds a meeting where it hears direct, spoken evidence from nominated clinical experts, patients and carers. The Committee uses all the evidence to make its first recommendations, in a document called the 'appraisal consultation document' (ACD). NICE sends all the consultees and commentators a copy of this document and posts it on the NICE website. Further comments are invited from everyone taking part.

When the Committee meets again it considers any comments submitted on the ACD; then it prepares its final recommendations in a document called the 'final appraisal determination' (FAD). This is submitted to NICE for approval.

Consultees have a chance to appeal against the final recommendations in the FAD. If there are no appeals, the final recommendations become the basis of the guidance that NICE issues.

Who is on the Appraisal Committee?

NICE technology appraisal recommendations are prepared by an independent committee. This includes health professionals working in the NHS and people who are familiar with the issues affecting patients and carers. Although the Appraisal Committee seeks the views of organisations representing health professionals,

patients, carers, manufacturers and government, its advice is independent of any vested interests.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

One study suggested that for most anti-D regimens the use of routine antenatal anti-D prophylaxis (RAADP) in primigravidae would be cost saving in terms of prevention of sensitisation and fetal loss. When RAADP for all women who are rhesus D (RhD)-negative was compared with RAADP for primigravidae who are RhD negative, the additional cost per incident of sensitisation prevented ranged from 2900 pounds sterling to 8300 pounds sterling depending on the regimen used. The cost per haemolytic disease of the newborn (HDN)-associated fetal loss avoided was between 42,000 pounds sterling and 120,000 pounds sterling. Another study suggested that a programme of RAADP would be cost saving if HDN was eradicated. Similar cost savings were predicted in a study of RAADP in England and Wales. The independent economic evaluation for the previous appraisal (National Institute for Health and Clinical Excellence [NICE] technology appraisal guidance 41) calculated that the incremental cost-effectiveness ratio (ICER) for RAADP was 11,000 pounds sterling – 13,000 pounds sterling per quality-adjusted life year (QALY) gained for primigravidae compared with no prophylaxis. For multigravidae compared with primigravidae, the ICER was 46,000 pounds sterling – 52,000 pounds sterling per QALY gained. The evaluation also suggested that adding a utility gain for avoiding fetal loss and interventions in the next pregnancy could reduce the ICER for multigravidae.

The Assessment Group modelled a cohort of RhD-negative primigravidae and multigravidae. It assumed the UK birth rate to be 12.1 per 1000 women and that 16% of the population is RhD negative. Each regimen for RAADP was compared with no RAADP. It was assumed that in their first pregnancy 61% of women who are RhD negative will have an RhD-positive fetus and are therefore at risk. Of the 61% of RhD-negative women who are at risk, 0.35% will be sensitised during their first pregnancy.

The Assessment Group assumed that the probability of fetal loss in pregnancies of sensitised women is around 4%, and that 6% of babies with HDN will have minor developmental problems. Within the model, a child with minor developmental problems had a health utility score of 0.85 and was assumed to incur a cost of 100 pounds sterling per year until 16 years of age. The Assessment Group assumed that 3% of babies with HDN would have major developmental problems. For these children, a health utility score of 0.42 and a cost of 458 pounds sterling per year, over a life expectancy of 60 years, were assumed. The costs of the preparations of anti-D immunoglobulin were taken from the 'British National Formulary' (edition 53). Each anti-D injection was assumed to incur an administration cost of 5 pounds sterling. The cost of managing a pregnancy in a sensitised mother was estimated to be 2885 pounds sterling.

In the base-case analysis for primigravidae who are RhD negative, comparison of RAADP with no prophylaxis resulted in ICERs of 14,802 pounds sterling

(Rhophylac), 19,438 pounds sterling (D-Gam), 25,372 pounds sterling (Partobulin SDF) and 113,827 pounds sterling (WinRho SDF) per QALY gained. For all women who are RhD negative (multigravidae and primigravidae) compared with RhD-negative primigravidae, the ICERs for RAADP were 34,336 pounds sterling (Rhophylac), 45,172 pounds sterling (D-Gam), 59,043 pounds sterling (Partobulin SDF) and 265,807 pounds sterling (WinRho SDF) per QALY gained.

The Assessment Group conducted additional analyses that combined primigravidae and multigravidae into one group. Treating the combined group with RAADP was compared with giving no RAADP. This comparison resulted in ICERs of 21,156 pounds sterling for Rhophylac, 27,810 pounds sterling for D-Gam, 36,326 pounds sterling for Partobulin SDF and 163,268 pounds sterling for WinRho SDF per QALY gained.

The Committee considered the results of the cost-effectiveness analysis. The cost-effectiveness analysis for three of the products resulted in ICERs of between 21,000 pounds sterling and 36,000 pounds sterling per QALY gained for giving RAADP to all women who are RhD negative, irrespective of the number of previous pregnancies, compared with not using RAADP. The Committee acknowledged that the costs associated with the management of a pregnancy in a sensitized woman and with caring for a child with severe disability had been underestimated in the model, and that the disutility of caring for a child with disability was not included in the model. The use of more realistic values for these parameters in the model would decrease the ICERs. The Committee concluded that RAADP is therefore a cost-effective use of National Health Service (NHS) resources.

Refer to Sections 4.2 and 4.3 of the original guideline document for details of the Assessment Group economic model and the Appraisal Committee considerations.

METHOD OF GUIDELINE VALIDATION

External Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Consultee organizations from the following groups were invited to comment on the draft scope, Assessment Report and the Appraisal Consultation Document (ACD) and were provided with the opportunity to appeal against the Final Appraisal Determination.

- Manufacturer/sponsors
- Professional/specialist and patient/carer groups
- Commentator organisations (without the right of appeal)

In addition, individuals selected from clinical expert and patient advocate nominations from the professional/specialist and patient/carer groups were also invited to comment on the ACD.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Note: This guidance replaces 'National Institute for Health and Clinical Excellence [NICE] technology appraisal guidance 41' issued in May 2002.

The Institute reviews each piece of guidance it issues. This review and reappraisal of routine antenatal anti-D prophylaxis (RAADP) for women who are rhesus D (RhD) negative has resulted in no change to the recommendations regarding which women are eligible for RAADP and the indications for its use. This review has appraised preparations that can be administered as single-dose or two-dose regimens, and recommends that the preparation with the lowest associated cost should be used.

Guidance

RAADP is recommended as a treatment option for all pregnant women who are RhD negative and who are not known to be sensitised to the RhD antigen.

When a decision has been made to give RAADP, the preparation with the lowest associated cost should be used. This cost should take into account the lowest acquisition cost available locally and costs associated with administration.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting the recommendations is not specifically stated.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate use of routine antenatal anti-D prophylaxis leading to reduced incidence of sensitization and hemolytic disease of the newborn (HDN)

POTENTIAL HARMS

All preparations of anti-D immunoglobulin carry a small risk of localised or generalised allergic reactions. Anti-D immunoglobulin is extracted from donor blood and, although blood donors are carefully screened for transmissible infections, there is always a small risk of the transmission of blood-borne infections.

For full details of side effects and contraindications, see the summary of product characteristics for each technology.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- This guidance represents the view of the Institute, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. The guidance does not, however, override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.
- Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way which would be inconsistent with compliance with those duties.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

- The Healthcare Commission assesses the performance of National Health Service (NHS) organizations in meeting core and developmental standards set by the Department of Health in "Standards for better health" issued in July 2004. The Secretary of State has directed that the NHS provides funding and resources for medicines and treatments that have been recommended by the National Institute for Health and Clinical Excellence (NICE) technology appraisals normally within 3 months from the date that NICE publishes the guidance. Core standard C5 states that healthcare organisations should ensure they conform to NICE technology appraisals.
- "Healthcare Standards for Wales" was issued by the Welsh Assembly Government in May 2005 and provides a framework both for self-assessment by healthcare organisations and for external review and investigation by Healthcare Inspectorate Wales. Standard 12a requires healthcare organisations to ensure that patients and service users are provided with effective treatment and care that conforms to NICE technology appraisal guidance. The Assembly Minister for Health and Social Services issued a Direction in October 2003 which requires Local Health Boards and NHS Trusts to make funding available to enable the implementation of NICE technology appraisal guidance, normally within 3 months.
- NICE has developed tools to help organisations implement this guidance (listed below). These are available on the NICE website (<http://www.nice.org.uk/TA156>) [see also the "Availability of Companion Documents" field].
 - A costing statement explaining the resource impact of this guidance
 - Audit support for monitoring local practice

IMPLEMENTATION TOOLS

Audit Criteria/Indicators
Patient Resources
Quick Reference Guides/Physician Guides

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

National Institute for Health and Clinical Excellence (NICE). Routine antenatal anti-D prophylaxis for women who are rhesus D negative. London (UK): National Institute for Health and Clinical Excellence (NICE); 2008 Aug. 27 p. (Technology appraisal guidance; no. 156).

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2008 Aug

GUIDELINE DEVELOPER(S)

National Institute for Health and Clinical Excellence (NICE) - National Government Agency [Non-U.S.]

SOURCE(S) OF FUNDING

National Institute for Health and Clinical Excellence (NICE)

GUIDELINE COMMITTEE

Appraisal Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Committee Members: Professor David Barnett, Professor of Clinical Pharmacology, University of Leicester; Dr Brian Buckley, Chairman, Incontact; Dr Carol Campbell, Senior Lecturer, University of Teesside; Professor Mike Campbell, Professor of Medical Statistics, University of Sheffield; Professor David Chadwick, Professor of Neurology, University of Liverpool; Dr Christine Davey, Senior Researcher, North Yorkshire Alliance Research and Development Unit; Dr Mike Davies, Consultant Physician, Manchester Royal Infirmary; Mr Richard Devereaux-Phillips, Public Affairs Manager, Medtronic; Professor Rachel A Elliott, Lord Trent Professor of Medicines and Health, University of Nottingham; Mrs Eleanor Grey, Lay member; Dr Dyfrig Hughes, Senior Research Fellow in Pharmacoeconomics, Centre for the Economics of Health and Policy in Health, University of Wales; Dr Catherine Jackson, Clinical Lecturer in Primary Care Medicine, Alyth Health Centre; Dr Peter Jackson, Clinical Pharmacologist, Sheffield Teaching Hospitals NHS Foundation Trust; Professor Peter Jones, Professor of Statistics and Pro Vice Chancellor for Research and Enterprise, Keele University; Ms Rachel Lewis, Practice Development Facilitator, Manchester Primary Care Trust; Damien Longson, Consultant in Liaison Psychiatry, North Manchester General Hospital; Professor Jonathan Michaels, Professor of Vascular Surgery, University of Sheffield; Dr Eugene Milne, Deputy Medical Director, North East Strategic Health Authority; Dr Simon Mitchell, Consultant Neonatal Paediatrician, St Mary's Hospital, Manchester; Dr Richard Alexander Nakielny, Consultant Radiologist, Royal Hallamshire Hospital, Sheffield; Dr Martin J Price, Head of Outcomes Research, Janssen-Cilag; Dr Philip Rutledge, GP and Consultant in Medicines Management, NHS Lothian; Mr Miles Scott, Chief Executive, Bradford Teaching Hospitals NHS Foundation Trust; Professor Andrew Stevens, Chair of Appraisal Committee C; Dr Cathryn Thomas, GP and Associate Professor, University of Birmingham; Mr William Turner, Consultant Urologist, Addenbrooke's Hospital, Cambridge

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Committee members are asked to declare any interests in the technology to be appraised. If it is considered there is a conflict of interest, the member is excluded from participating further in that appraisal.

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) format from the [National Institute for Health and Clinical Excellence \(NICE\) Web site](#).

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Routine antenatal anti-D prophylaxis for women who are rhesus D negative. Quick reference guide. London (UK): National Institute for Health and Clinical

- Excellence (NICE); 2008 Aug. 2 p. (Technology appraisal 156). Available in Portable Document Format (PDF) from the [National Institute for Health and Clinical Excellence \(NICE\) Web site](#).
- Routine antenatal anti-D prophylaxis for women who are rhesus D negative. Costing statement. London (UK): National Institute for Health and Clinical Excellence (NICE); 2008 Aug. 3 p. (Technology appraisal 156). Available in Portable Document Format (PDF) from the [NICE Web site](#).
 - Routine antenatal anti-D prophylaxis for women who are rhesus D negative. Audit support. London (UK): National Institute for Health and Clinical Excellence (NICE); 2008. 6 p. (Technology appraisal 156). Available in Portable Document Format (PDF) from the [NICE Web site](#).
 - Routine antenatal anti-D prophylaxis for RhD-negative women (review). Technology Assessment Report. The University of Sheffield, School of Health and Related Research (SchARR); 2007 Nov 28. 166 p. (Technology appraisal 156). Available in Portable Document Format (PDF) from the [NICE Web site](#).

Print copies: Available from the National Health Service (NHS) Response Line 0870 1555 455. ref: N1667. 11 Strand, London, WC2N 5HR.

PATIENT RESOURCES

The following is available:

- Routine antenatal anti-D prophylaxis for women who are rhesus D negative. Understanding NICE guidance. Information for people who use NHS services. London (UK): National Institute for Health and Clinical Excellence (NICE); 2008 Aug. 4 p. (Technology appraisal 156). Available in Portable Document Format (PDF) from the [National Institute for Health and Clinical Excellence \(NICE\) Web site](#).

Print copies: Available from the NHS Response Line 0870 1555 455. ref: N1668. 11 Strand, London, WC2N 5HR.

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC STATUS

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