I. Background
A. IgA deficiency is the most common type (1/500 to 700) human immunodeficiency in the Caucasian population. However, absolute deficiency (hence capable of forming anti-IgA) is much less common.
B. In severely IgA deficient patients with anti-IgA transfusion can result in anaphylaxis.
C. Anti-IgA may be “naturally” occurring without history of exposure, developed in response to IgA like-substance that are ubiquitous in the environment.
D. Anaphylactic reaction can develop with a small amount of IgA, may occur with the first transfusion: symptoms include respiratory distress, laryngeal edema and hypotension.
E. Many “deficient” (who meet the WHO criteria) individual have low levels of IgA, so they are not capable of forming anti-IgA, or can only form anti-IgA of limited specificity (e.g. IgA subclass-specific) and clinical consequence

II. Transfusion Options:
A. Autologous Transfusions
B. RBC:
   o Washed RBCs (wash with large volume saline, 2-3L)
   o RBC from IgA deficient donors
   o Deglycerolized, previously frozen RBCs. Deglycerolization is equivalent to washing
C. Platelet
   o Washed – this process adversely affect platelet recovery and function
   o Platelets from IgA deficient donors
D. Plasma products
   o Plasma from IgA deficient donors

III. Practical Issues
A. If time permits, when special products are requested for an “IgA deficient” patient, ask for more history or additional laboratory tests of adequate sensitivity (low detection limit) to confirm that the patient is truly severely IgA deficient. Do not lightly apply the label “IgA deficient”, as this commits the blood bank to procuring and supplying special blood products for this patient for life.
B. IgA deficiency should be considered in patients with anaphylactic reactions to transfusion.
C. American Red Cross maintains registry of rare confirmed IgA deficient donors, and can provide IgA deficient products from these donors.
D. Coordinate with clinicians, ensure lead time to procure products