https://doi.org/10.62587/AFJBMS.1.1.2025.10-18 ISSN: 3136-8026



African Journal of Biomedical Sciences

Journal homepage: https://www.afjbms.com/



Research Article **Open Access**

Evaluation of platelet transfusion practices and clinical outcomes in hospitalized patients: A retrospective study

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Article Info

Volume 1, Issue 1, July 2025
Received : 27 February 2025
Accepted : 19 June 2025
Published : 25 July 2025
doi: 10.62587/AFJBMS.1.1.2025.10-18

Abstract

Background: Platelet transfusion is essential for thrombocytopenic patients, but inappropriate use may expose patients to avoidable risks while consuming a scarce blood component. This study evaluated platelet transfusion practices, guideline appropriateness, transfusion response, and factors associated with poor platelet increment. **Methods:** This retrospective study included 420 platelet transfusion episodes among hospitalized adults. Indications, pre-transfusion platelet counts, product type, clinical factors, Corrected Count Increment (CCI), and outcomes were evaluated. Appropriateness was assessed against evidence-based thresholds, and predictors of poor increment were examined using multivariable logistic regression. **Results:** Of 420 transfusions, 26.9% were guideline-inappropriate, predominantly liberal prophylactic transfusions. Inappropriateness varied across departments and was highest in general medicine and surgery (38% each). Single-donor platelets produced a higher mean CCI than random-donor platelets (10.7 versus 8.8; $p<0.001$) and fewer poor increments (16% versus 30%; $p<0.001$). Splenomegaly, sepsis, disseminated intravascular coagulation, fever, and random-donor platelet use independently predicted poor increment, whereas pre-transfusion platelet count did not. **Conclusion:** Inappropriate platelet transfusion remained frequent and varied across clinical services. Greater adherence to restrictive thresholds and systematic assessment of transfusion response may improve platelet utilization and transfusion stewardship.

Keywords: *Platelet transfusion, Appropriateness, Prophylactic transfusion, Refractoriness, Blood management*

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1. Introduction

Platelet transfusion is a mainstay in the support of patients with thrombocytopenia, whether from the marrow failure of haematological disease and its treatment, from consumption, or from massive haemorrhage. Platelets are, however, a scarce and highly perishable component, with a shelf life of only a few days, and their transfusion is not without hazard, carrying the risks of febrile and allergic reaction, of bacterial contamination greater than

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that of other components, and of alloimmunisation and transfusion-associated lung injury (Goel *et al.*, 2019; Kreuger *et al.*, 2017). The judicious use of the component is therefore both a clinical and a stewardship imperative.

The evidence that should govern this use has matured considerably. A succession of randomised trials has established that, for the prevention of spontaneous bleeding in the stable thrombocytopenic patient, a restrictive prophylactic threshold of ten times ten to the ninth per litre is as safe as more liberal practice, that a low fixed dose is as effective as a higher one, and that in selected patients a therapeutic strategy, transfusing only when bleeding occurs, is a reasonable alternative to routine prophylaxis (Slichter *et al.*, 2010; Wandt *et al.*, 2012; Stanworth *et al.*, 2013). These findings have been consolidated into concordant guidelines that recommend the restrictive threshold for prophylaxis, higher thresholds only for procedures or active bleeding, and a single apheresis unit or its equivalent as the standard dose (Kaufman *et al.*, 2015; Estcourt *et al.*, 2017; Nahirniak *et al.*, 2015).

Practice has not kept pace with this evidence. Audits across many institutions have repeatedly found that a large fraction of platelet transfusions, often between a quarter and a half, are given outside the recommended thresholds, the commonest departure being prophylactic transfusion of the non-bleeding patient at a platelet count above the restrictive trigger (Cameron *et al.*, 2007; Kaur *et al.*, 2021; Chaudhary *et al.*, 2021). This liberal use is not evenly distributed, tending to be greater in the surgical and critical-care settings than in the haematology services that consume the most platelets and are most familiar with the evidence, and it exposes patients to the hazards of transfusion and depletes a scarce resource without a corresponding benefit (Charlton *et al.*, 2014; Ning *et al.*, 2016).

Alongside the question of when to transfuse lies the question of what to transfuse and how the response is measured. Platelets are supplied either as units pooled from several whole-blood donors, the random-donor product, or as a single-donor apheresis unit, and the corrected count increment, which adjusts the rise in platelet count for the dose given and the size of the patient, provides a standardised measure of the response and a means of recognising the refractoriness that follows repeated transfusion and intercurrent illness (Slichter, 2007; Trial to Reduce Alloimmunization to Platelets Study Group, 1997; Vassallo *et al.*, 2014). Whether the two products differ in the increment they achieve, and which clinical factors predict a poor response, bear directly on the effectiveness of transfusion (Hui *et al.*, 2023; Sahoo *et al.*, 2022).

This study was therefore undertaken to evaluate platelet transfusion practice in hospitalised patients against the evidence-based guidelines and to relate it to the response and outcome. Its objectives were to describe the pattern of use and to determine the proportion of transfusions that were guideline-inappropriate and how this varied between departments; to compare the appropriate and inappropriate transfusions in their pre-transfusion count and response; to compare the random-donor and single-donor products in the count increment they achieved and the reactions they provoked; and to identify the clinical predictors of a poor increment.

2. Materials and methods

2.1. Design and setting

This retrospective observational study evaluated 420 consecutive platelet transfusion episodes in hospitalised adult patients across the haematology and oncology, critical care, general medicine and surgical services. Each episode was the transfusion of one or more platelet units to a patient on a single occasion, constituted the primary unit of analysis. Transfusion records were reviewed together with the corresponding clinical and laboratory records to determine the indication, appropriateness, transfusion response, and relevant clinical outcomes. The study was reported in accordance with the recommendations for observational studies (Vandenbroucke *et al.*, 2007).

2.2. Data collected

For each episode the indication was classified as prophylactic in a non-bleeding patient, therapeutic for active bleeding, or transfusion in preparation for an invasive procedure. The pre-transfusion platelet count, the type of product, whether random-donor or single-donor apheresis, the dose in platelet units, and the department were recorded, together with the clinical factors known to affect the response, namely sepsis, splenomegaly,

fever and disseminated intravascular coagulation. The post-transfusion platelet count at one hour, the occurrence of a subsequent bleeding event or a transfusion reaction, the length of hospital stay and the 30-day mortality were also recorded.

2.3. Assessment of transfusion appropriateness and response

Each platelet transfusion episode was classified as appropriate or inappropriate against the prevailing guidelines. A therapeutic transfusion for active bleeding was appropriate at any count; a prophylactic transfusion was appropriate when the pre-transfusion count was $\leq$10 ×10y/L, or at or $\leq$20 ×10y/L in the presence of a risk factor such as sepsis or fever; and a pre-procedure transfusion was appropriate when the count was $\leq$50 ×10y/L. The response was quantified by the corrected count increment at one hour, calculated as the rise in platelet count multiplied by the body surface area and divided by the number of platelets transfused, and a value <7.5 was taken to denote a poor increment.

2.4. Statistical analysis

Categorical variables are summarised as counts and percentages and continuous variables as median with interquartile range or mean with standard deviation. The appropriateness of transfusion was compared across departments by the chi-square test. The appropriate and inappropriate transfusions, and the random-donor and single-donor products, were compared by the Mann-Whitney test for continuous measures and the chi-square or Fisher exact test for proportions. The independent predictors of a poor increment were identified by multiple logistic regression, which included the product type, sepsis, splenomegaly, fever, disseminated intravascular coagulation and the pre-transfusion count. A probability below 0.05 was accepted as significant.

2.5. Ethical considerations

The study was approved by the Institutional Ethics Committee before commencement and was conducted in accordance with the principles of the Declaration of Helsinki. Because it was a retrospective analysis of transfusion and clinical records, the requirement for individual informed consent was waived by the committee, and all records were anonymised and identified only by a study code.

3. Results

3.1. Pattern of use and appropriateness

Among the 420 platelet transfusion episodes, 256 (61.0%) were administered prophylactically to non-bleeding patients, 129 (30.7%) were therapeutic transfusions for active bleeding, and 35 (8.3%) were administered before an invasive procedure. Haematology/oncology accounted for 160 (38.1%) episodes, followed by general medicine (23.3%), intensive care (21.4%), and surgery (17.1%). Random-donor pooled platelets were used in 233 (55.5%) episodes and single-donor apheresis platelets in 187 (44.5%). Overall, 113 transfusion episodes (26.9%) were classified as guideline-inappropriate, with most inappropriate episodes representing prophylactic

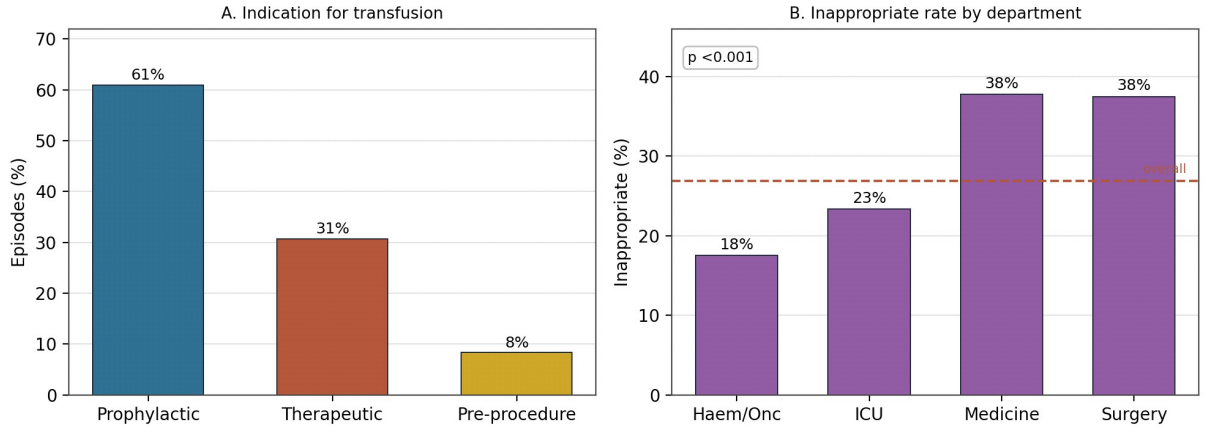


Figure 1: Indications for transfusion (A) and the proportion of inappropriate transfusions by department (B)

transfusions administered above the recommended platelet-count threshold. A poor one-hour platelet increment (CCI <7.5) occurred following 99 transfusion episodes (23.6%) (Table 1 and Figure 1).

Table 1: Pattern of platelet transfusion use in the 420 episodes

Characteristic	n (%)	Characteristic	n (%)
Prophylactic (no bleeding)	256 (61.0)	Therapeutic (active bleeding)	129 (30.7)
Pre-procedure	35 (8.3)	Haematology/Oncology	160 (38.1)
Intensive care	90 (21.4)	General medicine	98 (23.3)
Surgery	72 (17.1)	Single-donor (apheresis)	187 (44.5)
Random-donor (pooled)	233 (55.5)	Sepsis	108 (25.7)
Splenomegaly	71 (16.9)	Fever	131 (31.2)
Pre-count <= 10 x10^9/L	131 (31.2)	Pre-count 11-50 x10^9/L	252 (60.0)
Pre-count > 50 x10^9/L	37 (8.8)	Guideline-inappropriate	113 (26.9)
Poor increment (CCI<7.5)	99 (23.6)		

3.2. Departmental variation in transfusion appropriateness

The proportion of guideline-inappropriate transfusions varied across clinical departments. Haematology/oncology showed the lowest proportion of inappropriate transfusions (18%), followed by intensive care (23%), whereas general medicine and surgery each had an inappropriate transfusion rate of 38%. This difference across departments was statistically significant. Episodes classified as inappropriate were administered at a higher median pre-transfusion platelet count than appropriate episodes (23 versus 13 ×10y/L; p<0.001). However, the median CCI did not differ significantly between inappropriate and appropriate episodes (10.4 versus 9.8; p = 0.054), nor did the median absolute platelet-count increment (16.6 versus 15.5 ×10y/L; p = 0.230) (Tables 2 and 3; Figure 2).

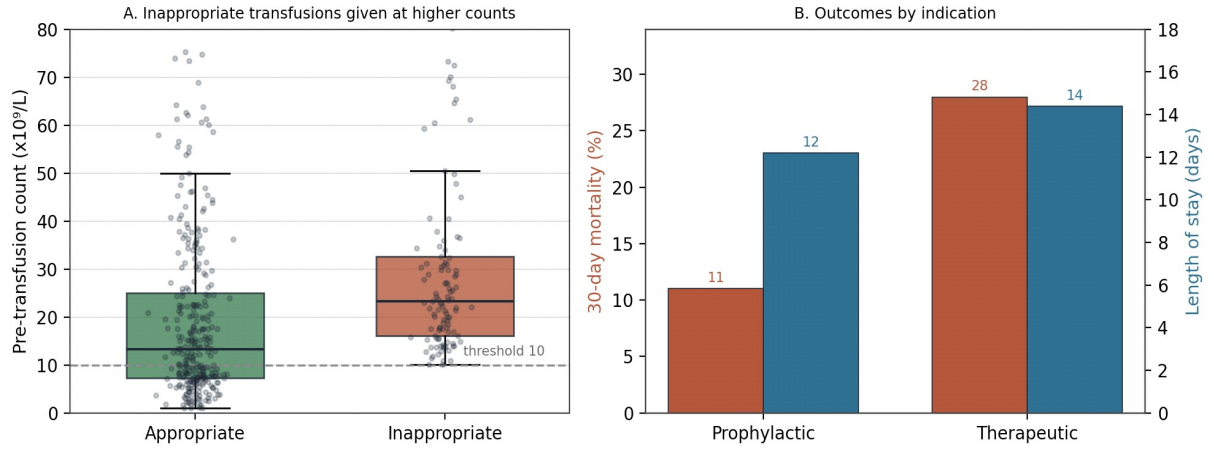


Figure 2: Pre-transfusion count by appropriateness (A) and outcomes by indication (B)

3.3. Comparison of platelet products

Single-donor apheresis platelets were associated with a greater post-transfusion platelet response than random-donor pooled platelets. The mean CCI was significantly higher following single-donor transfusion (10.7 versus 8.8; p<0.001), while the median absolute platelet-count increment was 20.8 ×10y/L compared

Table 2: Appropriateness of transfusion by department, and comparison of appropriate with inappropriate transfusions

Department/comparison	n	Appropriate	Inappropriate/p
Haematology/Oncology	160	82%	18%
Intensive care	90	77%	23%
General medicine	98	62%	38%
Surgery	72	62%	38%

Table 3: Comparison of appropriate and inappropriate transfusion episodes and clinical outcomes according to transfusion indication

Measure	Inappropriate	Appropriate	p
Median pre-transfusion count (x10^9/L)	23	13	<0.001
Median CCI	10.4	9.8	0.054
Median count increment (x10^9/L)	16.6	15.5	0.230
Outcomes by indication	**Prophylactic**	**Therapeutic**	**p**
30-day mortality (%)	11	28	<0.001
Median length of stay (days)	12.2	14.4	<0.001
Transfusion reaction (%)	7	6	0.833

with 13.0 ×10y/L following random-donor transfusion (p<0.001). A poor increment occurred in 16% of single-donor compared with 30% of random-donor transfusion episodes (p<0.001). Transfusion reactions occurred in 4% and 8% of episodes, respectively, although this difference was not statistically significant (p = 0.159) (Table 4 and Figure 3).

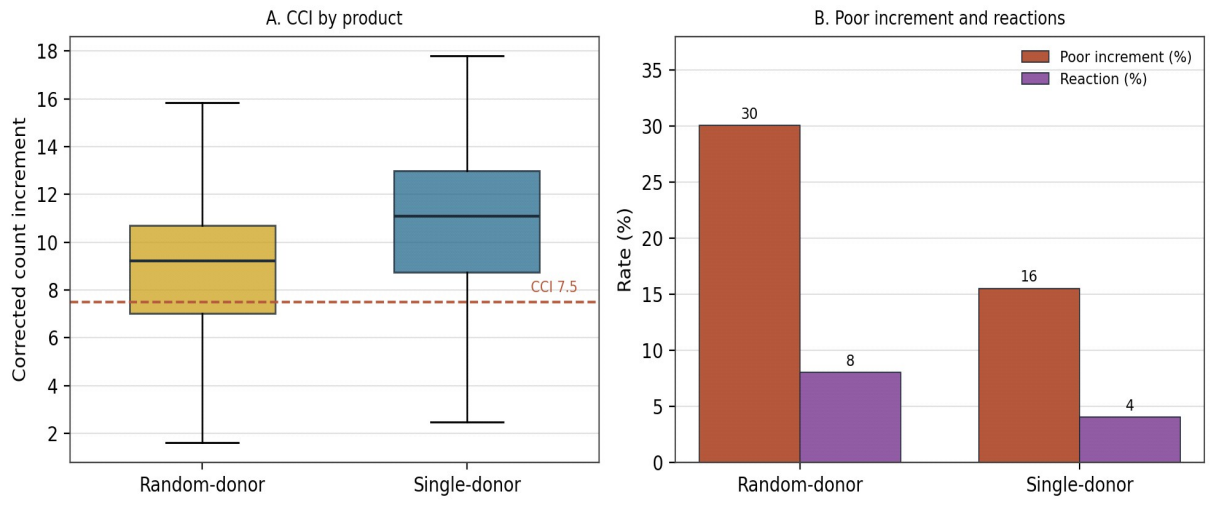


Figure 3: Corrected count increment by product (A) and the frequency of poor increment and reactions (B)

Table 4: Comparison of random-donor and single-donor platelet products

Measure	Random-donor	Single-donor	p
Mean CCI	8.8	10.7	<0.001
Poor increment (%)	30	16	<0.001
Median increment (x10^9/L)	13.0	20.8	<0.001
Transfusion reaction (%)	8	4	0.159

3.4. Predictors of a poor platelet increment

A poor one-hour platelet increment occurred following 23.6% of transfusion episodes. In multivariable logistic regression, splenomegaly showed the strongest association with poor increment (OR approximately 18.7, 95% CI 8.6–40.8), followed by sepsis (OR 10.1, 95% CI 5.2–19.4), DIC (OR 3.9, 95% CI 1.9–8.3), and fever (OR 2.6, 95% CI 1.4–4.7). Use of random-donor pooled platelets was independently associated with greater odds of poor increment compared with single-donor platelets (OR 3.4, 95% CI 1.8–6.2). In contrast, a pre-transfusion platelet count >20 ×10y/L was not independently associated with poor increment (OR 0.9, 95% CI 0.5–1.7). These findings indicate that both platelet product type and clinical factors associated with platelet consumption or sequestration were independently related to early post-transfusion response (Figure 4).

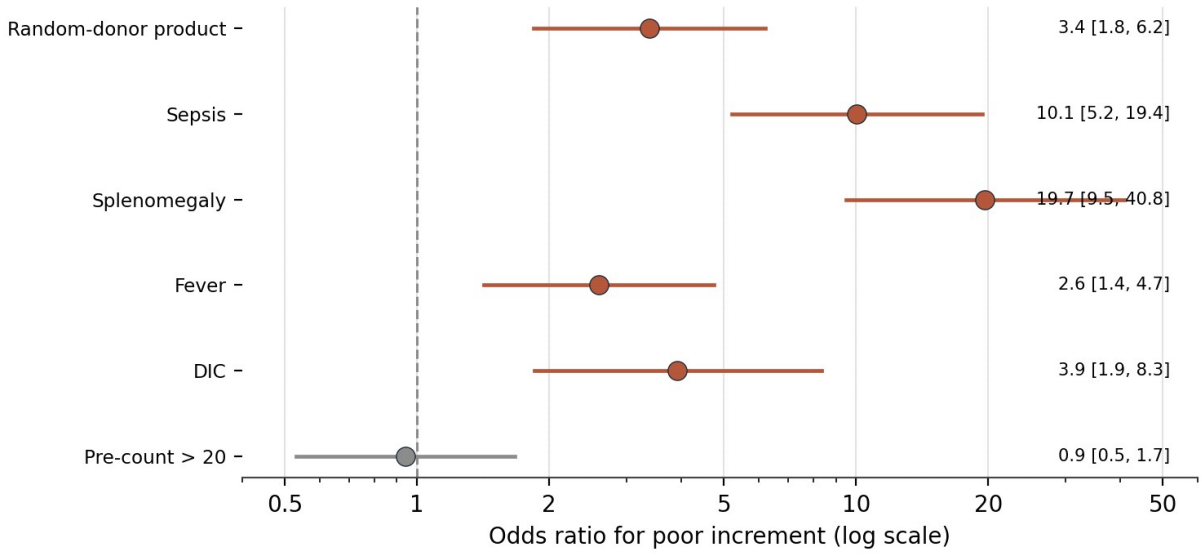


Figure 4: Independent predictors of a poor platelet increment

4. Discussion

This retrospective evaluation identified substantial variation in platelet transfusion practice and response among hospitalized patients. More than one-quarter of transfusion episodes were classified as inconsistent with the guideline thresholds adopted in this study, with inappropriate use occurring predominantly in prophylactic transfusion and varying across clinical departments. Single-donor apheresis platelets were associated with greater corrected and absolute platelet-count increments and a lower frequency of poor response than random-donor pooled platelets. In addition, splenomegaly, sepsis, DIC, fever, and random-donor platelet use were independently associated with poor one-hour platelet increment. Together, these findings identify potentially modifiable aspects of platelet utilization while emphasizing the substantial influence of the patient's clinical condition on transfusion response.

The finding that more than a quarter of transfusions were inappropriate, and that almost all of the inappropriate transfusions were liberal prophylaxis above the restrictive threshold, reproduces the central

and remarkably consistent finding of the audit literature. It is against exactly this practice that the randomised trials have argued, having shown that the restrictive threshold of ten prevents bleeding as effectively as more liberal transfusion, so that platelets given to the stable non-bleeding patient at a higher count add hazard and cost without benefit. That the inappropriate transfusions in this study were given at a markedly higher pre-transfusion count than the appropriate ones, while achieving no greater increment and, among the prophylactic transfusions, no reduction in bleeding, is the concrete local expression of this argument.

The variation in appropriateness across departments identifies potential targets for transfusion stewardship. Haematology/oncology demonstrated the lowest proportion of guideline-inappropriate transfusions, whereas general medicine and surgery showed the highest proportions. Similar variation between clinical services has been described in previous transfusion audits. The present study cannot determine whether these differences reflect variation in case mix, clinical decision-making, familiarity with transfusion guidelines, or other service-specific factors. Nevertheless, department-level variation suggests that targeted interventions, including guideline-based order sets, clinician education, and prospective review of platelet requests, may help improve adherence to evidence-based transfusion thresholds (Pavenski *et al.*, 2018).

Single-donor apheresis platelets were associated with a higher CCI, a greater absolute platelet-count increment, and a lower frequency of poor increment than random-donor pooled platelets. These findings are consistent with differences in platelet dose and product characteristics reported previously (Cid and Lozano, 2020). However, because platelet product selection was not randomized, differences in patient characteristics or clinical indications may have contributed to the observed association. The findings therefore support an association between single-donor platelet use and greater early platelet response but do not establish intrinsic superiority of one product in all clinical settings.

That the predictors of a poor increment were splenomegaly, sepsis, disseminated intravascular coagulation and fever, the non-immune clinical causes of accelerated platelet consumption and sequestration, rather than the pre-transfusion count, is both expected and instructive. It indicates that a poor response in these patients is not usually a failure of dosing to be corrected by transfusing more, but a consequence of the underlying illness, so that the appropriate response is to treat the illness and to avoid the reflex of repeated transfusion that alloimmunises the patient and consumes the resource. The worse outcomes of the therapeutic transfusions, given to actively bleeding and often critically ill patients, reflect the severity of the conditions that prompt them rather than any harm of the transfusion, and are a reminder that the indication carries prognostic information.

The practical message is therefore clear and actionable. Adherence to the restrictive prophylactic threshold, reinforced by order sets and prospective screening and directed particularly at the surgical and medical services, would reduce inappropriate use without harm; the corrected count increment should be measured to gauge the response and to recognise refractoriness; the apheresis product should be preferred where a reliable increment matters; and a poor increment in the septic or splenomegalic patient should prompt attention to the underlying illness rather than reflexive re-transfusion.

5. Strengths and limitations

This study evaluated a relatively large number of platelet transfusion episodes across multiple clinical services and incorporated both guideline appropriateness and objective assessment of early platelet response. Several limitations should nevertheless be considered. First, the design is retrospective, so that it depends on the completeness of the records and cannot establish that the inappropriate transfusions caused harm or that the liberal ones failed to benefit, only that they were given without a guideline indication and without a demonstrable advantage. The judgement of appropriateness rests on the thresholds adopted, which, though evidence-based, are not the only ones in use, and the classification of a transfusion as prophylactic or therapeutic depends on the accuracy of the recorded indication. The corrected count increment was assessed at one hour, which captures the immediate recovery but not the survival of the transfused platelets that a twenty-four-hour increment would add, and the study did not distinguish the immune from the non-immune causes of a poor increment by antibody testing. Finally, the cohort was drawn from a single institution, so that the pattern of use and the departmental variation may differ elsewhere, and the findings await confirmation in a multicentre audit.

6. Conclusion

More than one-quarter of platelet transfusion episodes in this retrospective study were inconsistent with the guideline thresholds adopted for evaluation, with inappropriate use occurring predominantly in prophylactic transfusion and varying substantially across clinical departments. Inappropriate episodes were administered at higher pre-transfusion platelet counts without a significantly greater corrected or absolute platelet-count increment. Single-donor apheresis platelet use was associated with a greater early platelet response and a lower frequency of poor increment than random-donor pooled platelet use. Poor platelet increment was independently associated with splenomegaly, sepsis, DIC, fever, and random-donor platelet use, whereas the pre-transfusion platelet count was not independently associated with response. These findings support greater attention to guideline-based transfusion thresholds, systematic assessment of post-transfusion response, and clinical factors associated with platelet refractoriness. Department-specific transfusion stewardship strategies may help reduce potentially avoidable platelet use. Prospective multicentre studies are required to validate these findings and determine whether targeted stewardship interventions improve platelet utilization and patient outcomes.

Ethical approval

The study was approved by the Institutional Ethics Committee and was conducted in accordance with the Declaration of Helsinki. As a retrospective analysis of anonymised records, the requirement for individual consent was waived.

Conflict of interest

The authors declare that no conflict of interest exists in relation to this work.

Funding

This work received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

Data availability

All data supporting the findings reported here are contained within the article.

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Cite this article as: Daniel O. Adeyemi (2025). Evaluation of platelet transfusion practices and clinical outcomes in hospitalized patients: A retrospective study. *African Journal of Biomedical Sciences*. 1(1), 10-18. doi: 10.62587/AFJBMS.1.1.2025.10-18.