

Title: MECHANISMS OF BLEEDING REDUCTION INDUCED BY APROTININ DURING CARDIOPULMONARY BYPASS : A CONTROLLED STUDY

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Effectiveness of Aprotinin (Trasylol) on bleeding during cardiopulmonary bypass (CPB) has been well established. Mechanisms of action were investigated in a double blind study performed on 20 patients who underwent aorto coronary bypass and were randomly included in Placebo(P) or in Aprotinin(A) group.

Patients characteristics: age (A: 60.4±8.1, P: 62.8±4.64 years), number of grafts (A: 2.6±.5, P: 2.6±.5) and preoperative Left Ventricular Ejection Fraction (A: 50 ± 8.3 %, P: 48 ± 5 %), no aspirin during 8 days prior to the operation.

Aprotinin Protocol: loading dose of 280 mg prior to incision, 280 mg into the membrane oxygenator prime, and a continuous infusion of 50 mg/h from anesthesia induction until ICU arrival. Heparinemia during CPB was kept over 4Units/ml. Blood loss from mediastinal drainage was recorded for each patient. Blood was sampled before anesthesia(1), 30 min after start of CPB(2), 5 min after aortic clamp release(3) and after heparin neutralization(4). Samples were studied to determine: 1° specific fibrin degradation products as D Dimers complex (DDE),

2° Platelet function by Ristocetin Agglutination,
3° tissue Plasminogen Activators (tPA),
4° β Thromboglobulin (BTG) and platelets number.

RESULTS: ANOVA mean 1-4,

	1	2	3	4	ANOVA
DDE (ng/ml)A	102	57	81	461	<.001
P	280	338*	710**	1944**	
RA	A 100	103	100	92	<.001
(%control) P	100	78*	61**	52**	
PLATELETS	A 250	125	133	111	ns
(1000/mm3) P	276	122	143	135	
tPA (ng/ml)A	8.3	6.7	10.6	18.4	ns
P	6.8	10.6	11.8	18.4	
BTG (ng/ml)A	117	117	180	290	ns
P	98	106	182	283	
PK	A 100	73	69	73	ns
(%control) P	100	69.5	62	68.8	

p<0.05 *, p<0.005 **

NEGATIVE CORRELATIONS

DDE2 vs RA(4) p<0.001, vs RA(3) p<0.008

DRAINAGE VOLUME

	MEAN	SEM	WILCOXON
(ml) A	277	±46	p≤ 0.04
P	629	±189	

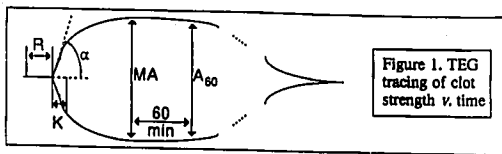
Those findings suggest that Aprotinin acts by plasmin inhibition with a resulting protective effect on platelet GPIb receptors break down on the platelet membrane. Moreover A inhibits tPA effects on the hemostatic clots of the wound closure
REFERENCES: Bidstrup BP et al, J Thorac. Cardiovasc. Surg., 1989, Vol197, 364.

A1206

TITLE: IS THE THROMBOELASTOGRAPH A CLINICALLY USEFUL PREDICTOR OF BLOOD LOSS AFTER BYPASS?

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The thromboelastograph (TEG) may assist recognition and management of coagulopathies after cardiopulmonary bypass (CPB).¹ Fig.1 displays TEG measurements: R and K reflect coagulation time; α is speed of clot formation; MA is maximum clot strength; A₆₀ is clot strength 60 min later; whole blood clot lysis index (WBCLI=A₆₀/MA) measures clot breakdown. WBCLI<0.8 indicates fibrinolysis.² This study determined whether TEG measurements correlated with fibrin split products $\geq 10\mu\text{g/ml}$ (+FSP) and predicted blood loss after CPB.



Methods: After institutional approval and informed consent, patients undergoing cardiac surgery donated blood prior to skin incision (FSP1, TEG1), after protamine (TEG2), and again 2 hrs after sternal closure (FSP3, TEG3). Mass of blood drained via mediastinal tubes over 12 hrs determined blood loss. Correlation coefficients compared TEG data with blood loss. WBCLI cut-offs of 0.8 and 0.05 divided patients into groups. ("Tear-drop" TEG patterns occur at WBCLI<0.05.) Chi-sq statistic compared frequency data; unpaired t-test compared grouped continuous variables.

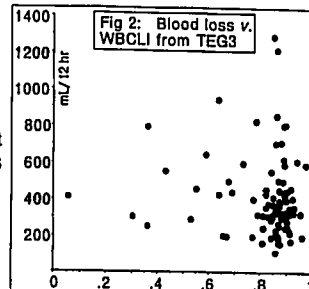
Results: No patient had +FSP prior to skin incision, but 16/88 had WBCLI<0.8 and 1/88 WBCLI=0. WBCLI after protamine (TEG2) predicted blood loss (table). After operation (TEG3), WBCLI correlated with neither +FSP nor blood loss (table). WBCLI (fig.2), R, K, and α did not correlate with blood loss; MA (r=.34) and A₆₀ (r=.25) correlated poorly. +FSP after surgery did not affect R, K, α , A₆₀, or WBCLI, and minimally affected MA (65 v. 61 P<.04).

TABLE:

	WBCLI ≥ 0.8	< 0.8	≥ 0.05	< 0.05
TEG2 Bld loss	384±188(SD)	525±321*	386±182	808±428*
TEG3 +FSP3	15/70	8/19	23/88	0/1
TEG3 Bld loss	400±220	463±221	413±222	412

*N=16/86, P=0.023 | #N=5/86, P=0.0001

Discussion: TEG3 parameters predict neither presence of FSP nor post-op bleeding. Post-op TEG appears to provide no useful information. TEG2 did predict blood loss, confirming that fibrinolysis occurs and corrects with time. However, >1 hr is needed to measure WBCLI. By this time, fibrinolysis has subsided. TEG2 information is too tardy for therapeutic decisions.



References:

1. SPIESS BD, ET AL.: J CLIN MONIT 3:25-30, 1987.
2. KANG YG, ET AL.: ANESTHESIOLOGY 66:766-773, 1987.