

COVID-19–associated Coagulopathy

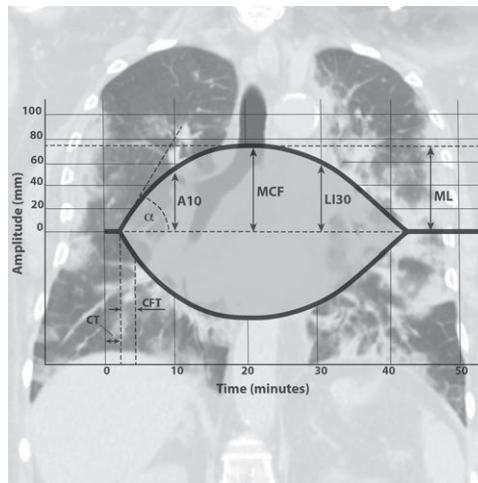
Less Fibrinolysis Can Be More Harmful!

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With more than 300,000 deaths, the United States is the country with the highest coronavirus disease 2019 (COVID-19) death toll globally, and the hospitalization attributable to COVID-19 continues to increase. Beyond respiratory and renal failure, COVID-19–associated coagulopathy is a major challenge with a very high incidence of thromboembolic complications.¹ In contrast to bacterial sepsis and disseminated intravascular coagulation, standard coagulation tests such as activated partial thromboplastin time, prothrombin time, and antithrombin level do not significantly change in most COVID-19 patients, despite a high incidence of thrombotic events.² This important finding further emphasizes that the classical cascade model of hemostasis and standard coagulation tests that focus on plasmatic clotting times do not reflect the pathophysiology of thromboinflammatory response/

immunothrombosis as it occurs in COVID-19. With acute infection of the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) virus, virus–cell and cell–cell–interactions, particularly among platelets, macrophages, neutrophils, and endothelial cells, play an essential role. Accordingly, the cell-based model of hemostasis and whole blood viscoelastic and platelet function tests are more appropriate to mirror the pathophysiology of COVID-19–associated coagulopathy.^{3,4}

In the current issue of *ANESTHESIOLOGY*, Heinz *et al.*⁵ report fibrinolysis resistance and platelet aggregation in critically ill COVID-19 patients measured with thromboelastometry and whole blood impedance aggregometry. In



“...the systemic inflammatory response syndrome of acute infections, sepsis, disseminated intravascular coagulation, and COVID-19 are characterized by different viscoelastic and platelet function patterns.”

their study, critically ill COVID-19 patients showed hypercoagulability that was characterized by greater values of overall maximum clot firmness and the corresponding contribution of fibrin, as well as a greater fibrinolysis resistance to a tissue plasminogen activator (tPA) challenge—characterized by a longer lysis time. This is consistent with the recently published data by Nougier *et al.*,⁶ noting that fibrinolysis resistance in tPA–thromboelastometry was associated with increased plasmin-activator inhibitor-1 concentrations. This thromboelastometry test modification has already been developed and validated previously to assess the resistance of clots against a tPA–challenge (*e.g.*, in patients with increased or decreased thrombin generation⁷). Other authors report hypofibrinolysis or fibrinolysis shutdown in patients with severe COVID-19, characterized by maximum lysis within a 60-min run-time of less than 3.5%. Creel-Bulos *et al.*⁸ reported that eight of nine (89%) COVID-19 patients with thrombosis met the criteria for *fibrinolysis shutdown*, and eight of 11 (73%) patients with fibrinolysis shutdown developed thrombosis despite anticoagulation. In contrast, only one of 14 (7%) patients with physiologic fibrinolysis developed a thrombosis. Both thromboelastography (area under the receiver operating characteristics curve [AUC], 0.74 [95% CI, 0.58 to 0.9]; $P = 0.021$)⁹ and thromboelastometry (AUC, 0.8 [95% CI, 0.7 to 0.9]; $P = 0.001$)¹⁰ confirmed that hypofibrinolysis was associated with an enhanced incidence of thrombosis. In both studies, the combination of maximum lysis and

Image: J. P. Rathmell.

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D-dimer concentrations provided the highest sensitivity and specificity of thromboembolic risk prediction (AUC, 0.92 [95% CI, 0.8 to 1]; $P < 0.001$)¹⁰ as well as renal failure with the need for dialysis. For clinical interpretation, the combination of both hypofibrinolysis and elevated D-dimer concentrations has resulted in some confusion because elevated D-dimer concentrations have been misinterpreted as a sign of hyperfibrinolysis.¹¹ In fact, D-dimer concentrations rise with plasma fibrinogen concentration and thrombin generation, which are both increased in COVID-19, but only 0.02% of the fibrinogen mass is cleaved to D-dimers in COVID-19.^{3-6,12} Accordingly, elevated D-dimer concentrations reflect an increased fibrin deposition (microthrombosis) rather than an increased fibrin breakdown (fibrinolysis) in severe COVID-19. To that effect, the combination of increased fibrin deposition and hypofibrinolysis/fibrinolysis shutdown results in thrombosis of the microcirculation with subsequent failure of the lungs and kidneys as well as neurologic disorders. This is not a new finding, because hypofibrinolysis has already been shown to discriminate between systemic inflammatory response syndrome and bacterial sepsis and to predict mortality in sepsis as reported previously.¹³⁻¹⁵

The current publication by Heinz *et al.* also reports only a slightly lower platelet aggregation attributable to adenosine diphosphate stimulation in critically ill patients with

COVID-19 compared with a healthy controls.⁵ This is contrary to findings in studies assessing viscoelastic and platelet function testing, where decreased maximum clot firmness and decreased platelet aggregation have been reported as early signs of bacterial sepsis and mortality.¹⁶⁻¹⁸

Limitations of the present study should be considered, because the number of patients evaluated was low and viscoelastic and platelet function testing were performed in ventilated patients after a mean of 7 days in the intensive care unit on one single occasion. Further, this study does not provide data on early COVID-19 hemostasis changes or during the clinical course of COVID-19 from hospital admission to discharge or death. Currently, other multicenter studies are underway to answer these questions (*e.g.*, the ROTEM Sigma in Hospitalized COVID-19 Patients [ROHOCO] Study, recruiting 500 patients in 16 hospitals and 11 countries; DRKS00023934).³ Of note is that viscoelastic testing is reported to be superior to standard plasmatic coagulation tests such as activated partial thromboplastin time and prothrombin time in predicting thrombosis in COVID-19.^{2,8-10}

During the last 150 yr, the knowledge about thrombosis has evolved from the macropathological model of the Virchow triad of venous thrombosis—based on blood flow, blood constituent and vessel wall issues (fig. 1)—to a micropathological model of thrombosis—characterized by tissue factor

Virchow Triad of Venous Thrombosis

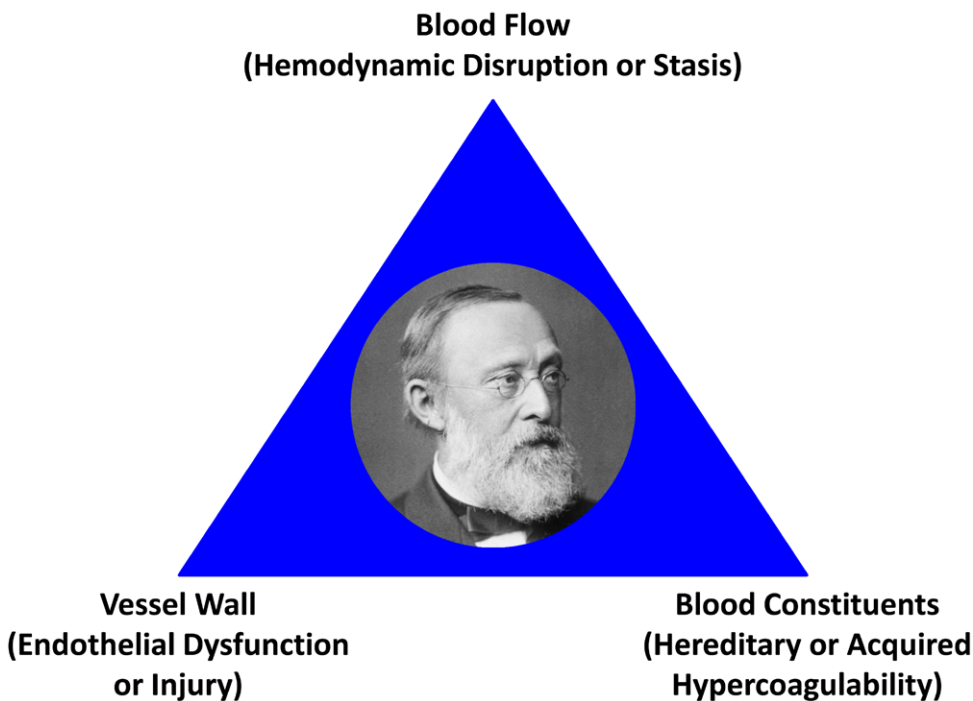


Fig. 1. Virchow triad of venous thrombosis.

Micropathological Triad of Thrombosis and COVID-19 and corresponding Changes in Thromboelastometry Results

Tissue Factor Expression on Circulation Cells and Microparticles
(Reduced Coagulation Time in non-activated Tests)

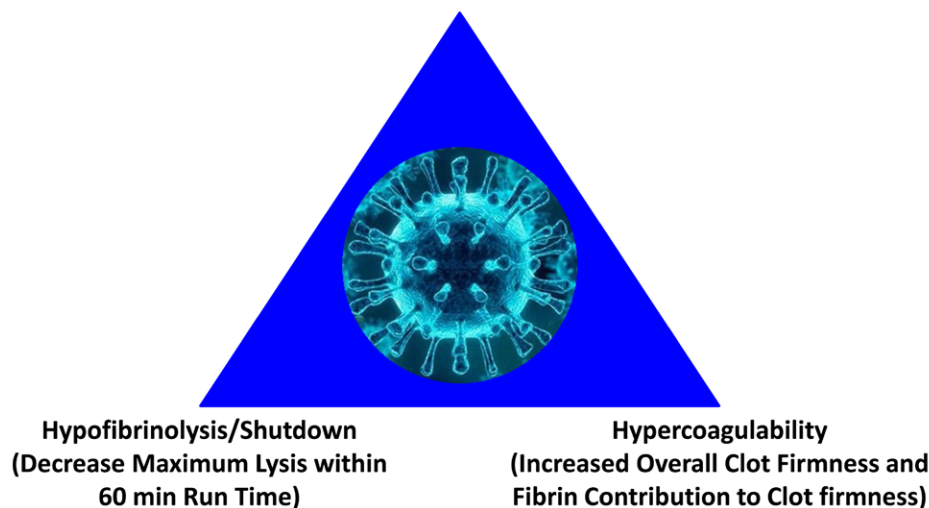


Fig. 2. Micropathological triad of thrombosis and COVID-19 and corresponding changes in thromboelastometry results.

expression of circulating cells and microparticles, hypercoagulability, and hypofibrinolysis (fig. 2). These changes on the cellular level are not reflected by plasmatic coagulation tests but by whole blood viscoelastic testing and are characterized by decreased coagulation times in nonactivated viscoelastic tests, increased clot firmness in viscoelastic tests with and without platelet contribution, as well as hypofibrinolysis/fibrinolysis shutdown (thromboelastometry triad of thrombosis and COVID-19).^{1,2,8–10,19} Notably, the systemic inflammatory response syndrome of acute infections, sepsis, disseminated intravascular coagulation, and COVID-19 are characterized by different viscoelastic and platelet function patterns.^{3,18} We believe that differentiation and outcome management strategies can be improved by multimodal testing that includes the combination of viscoelastic, platelet function, and conventional biomarkers such as D-dimers.^{9,10,20} In combination with big data, machine learning, and pattern recognition, this may offer in the near future opportunities to detect these important issues early and may allow for personalized therapy in these critically ill patients in terms of precision medicine.^{21,22}

Competing Interests

Dr. Görlinger is the medical director of Tem Innovations GmbH (Munich, Germany) since July 2012. Dr. Levy acts as a member of steering committees for Octapharma (Lachen, Switzerland), Instrumentation Laboratory (Bedford, Massachusetts), and Merck (Kenilworth, New Jersey).

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