values between patients with respect to packed red blood cells administration revealed significantly lower test values in the group of patients exposed to RBC (P = 0.002) [2]. The role of ASA and CLO administration management should be separately assessed by drug-specific platelet function tests, thus facilitating an individual therapeutic approach for each antiplatelet agent preoperatively. In addition, intraoperative assessment of platelet function and viscoelastic blood clot properties during CPB can reveal a further degree of haemostatic disorder and its relation to bleeding extent as well as transfusion requirements [3]. Pre- and intraoperative assessment of platelet function and viscoelastic blood clot properties can distinguish the influence of pre-existing, antiplatelet drugs-related and CPB-acquired haemostatic disorders, allowing detection of risk factors and enabling preoperative (procedure timing, risk stratification, antiplatelet therapy discontinuation management) and intraoperative (targeted administration of desmopressin, tranexaminic acid and procoagulant blood components) practice modifications, which may further lead to improvement in transfusion as well as bleeding, and thus clinical outcome.

REFERENCES


LETTER TO THE EDITOR RESPONSE

Reply to Petricevic et al.

Luca Salvatore De Santoa,*, Cristiano Amarellib, Michelangelo Scardoneb and Gianpaolo Romanoa

a Department of Surgical and Medical Sciences, University of Foggia, Foggia, Italy
b Department of Cardiovascular Surgery and Transplant, Azienda Dei Colli - V. Monaldi Hospital, Naples, Italy

* Corresponding author. Department of Surgical and Medical Sciences, University of Foggia, Viale Colli Aminei 491, 80131 Naples, Italy. Tel: +39-0-815922118; fax: +39-0-817433449; e-mail: l.desanto@unifg.it, luca.desanto@ospedalemonaldi.it (L.S. De Santo).

Received 25 March 2013; accepted 25 March 2013

Keywords: Coronary surgery • Blood transfusion • Platelet function

We are grateful to Petricevic and co-workers for the interest they showed in reading our paper [1, 2]. Table 1 of the manuscript discloses the preoperative exposure of transfused and non-transfused subgroups to both aspirin (ASA) and clopidogrel (CLO). ASA and CLO did not prove to be independent predictors of blood transfusion requirement in this study. Anyhow, we fully agree with Petricevic that evaluating platelet function is a crucial tool in enhancing perioperative patient blood management, and we have added these measures to our transfusion algorithm in the most recent practice. More, as authoritative stated by Ranucci et al. [3], tests of platelet function, measured intraoperatively and postoperatively (not preoperatively), correlate best with the occurrence and time course of post-CPB bleeding... The measure of platelet function during the intraoperative or postoperative period is thus critical to devising accurate and appropriate transfusion strategies so that bleeding patients can be treated with only those allogeneic blood products that they actually need. Open questions include which platelet function tests to use and which other measures should be included in a transfusion algorithm. In this respect, the most recent research of Petricevic et al. [4] certainly adds to the current knowledge.

REFERENCES


