Patient Blood Management

The Intraoperative Period

Keyvan Karkouti

Head, Department of Anesthesia and Pain Management

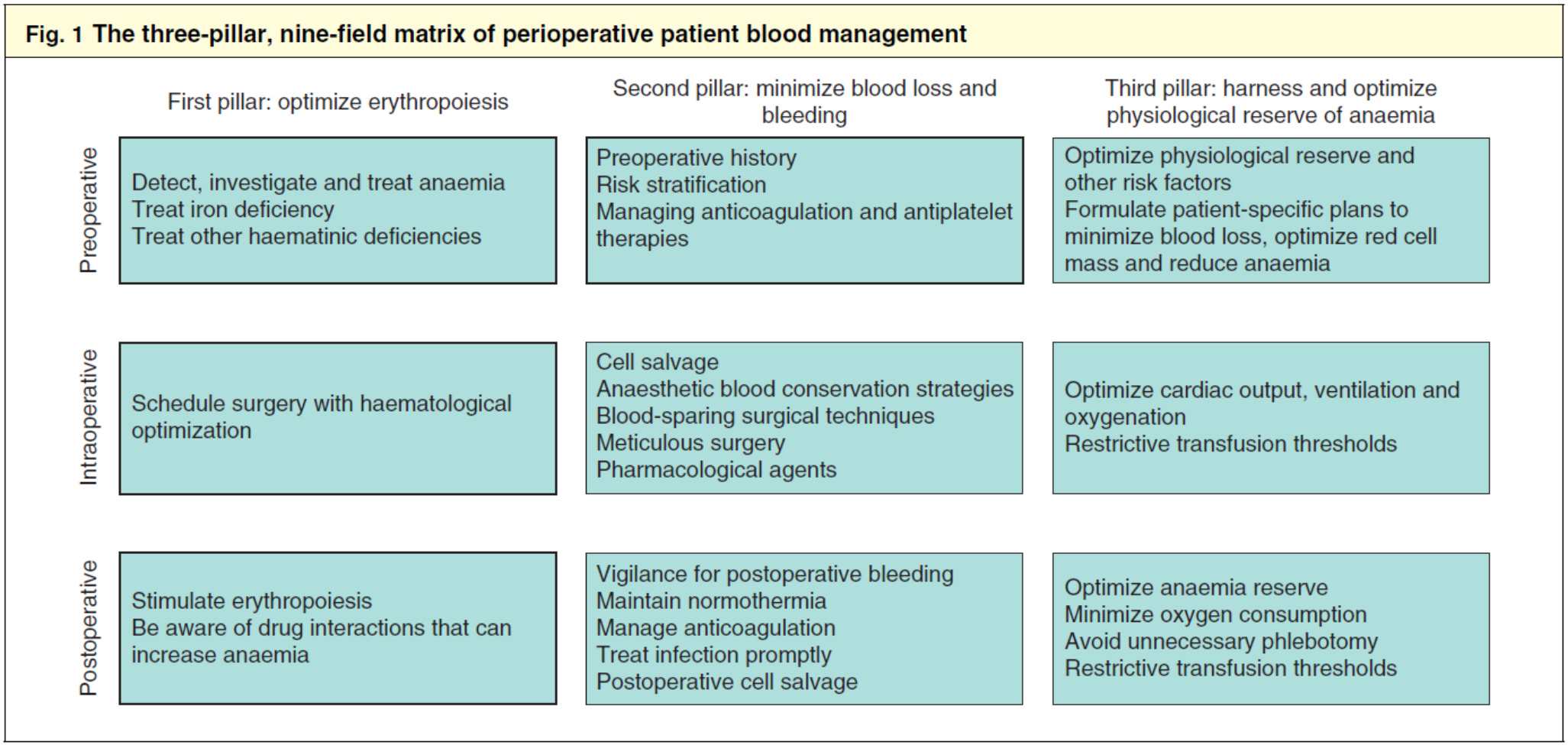
University Health Network, Sinai Health System, Women's College Hospital

Senior Scientist, Toronto General Hospital Research Institute

Department of Anesthesia & Pain Management

Three Pillars of PBM

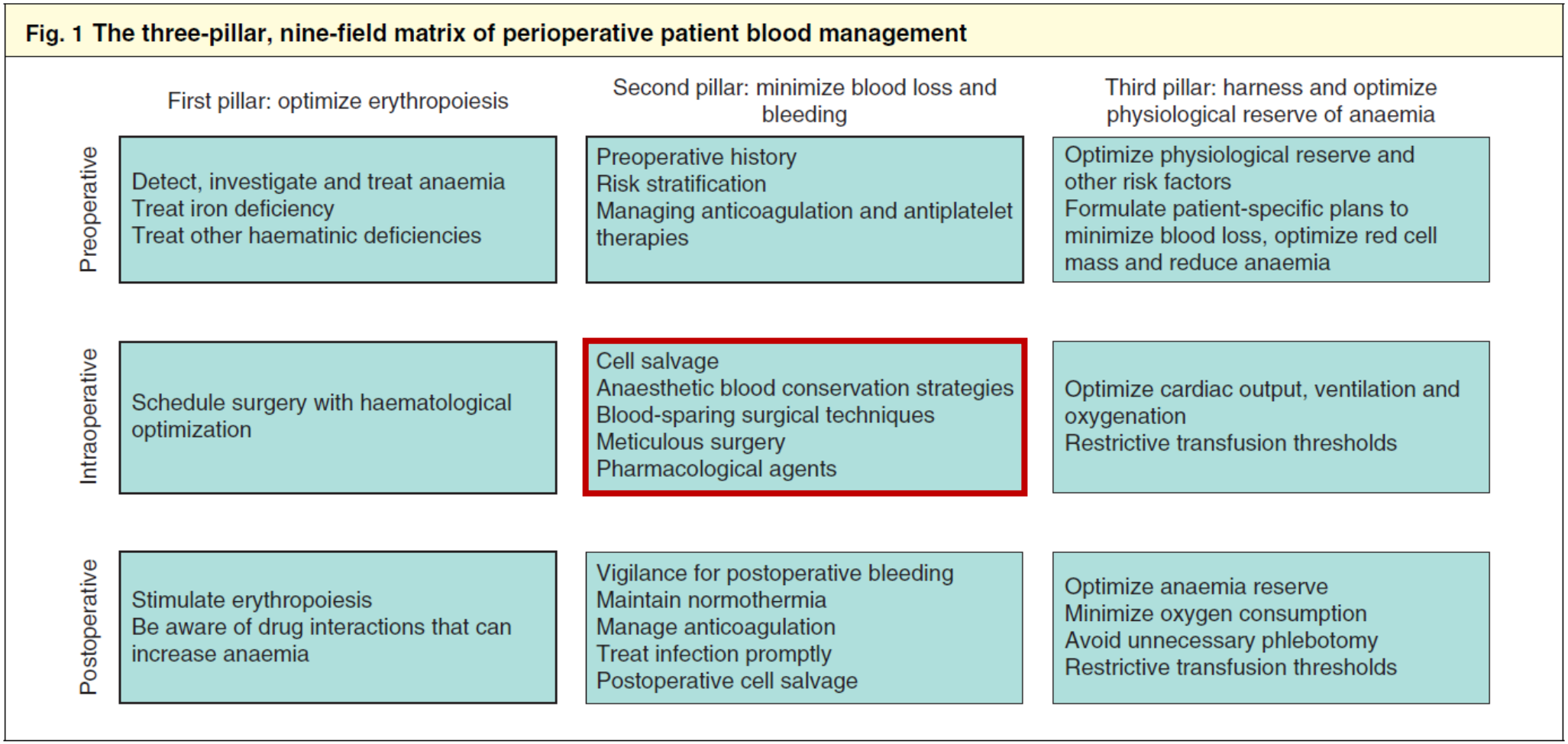
Fig. 1 The three-pillar, nine-field matrix of perioperative patient blood management



Shah et al. BJS 2020;107:e26-e38

Three Pillars of PBM

Fig. 1 The three-pillar, nine-field matrix of perioperative patient blood management



Shah et al. BJS 2020;107:e26-e38

Practical criteria for adoption of modalities

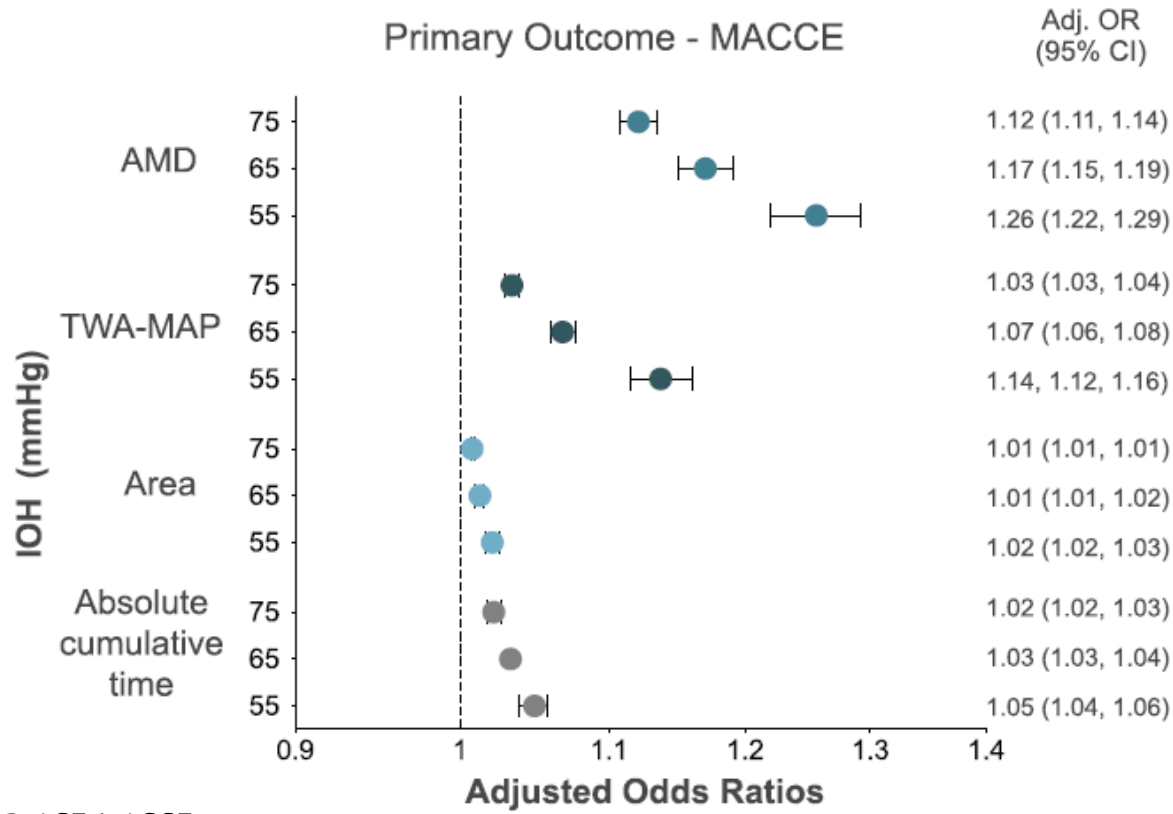
1. Has to be effective
2. Has to be at least as safe as transfusion
3. Costs should be reasonable

Anesthetic blood sparing techniques

- Controlled (permissive) hypotension
  - Lowering of blood pressure to mean ~ 50–60 mmHg
  - Objectives:
    - Reducing blood loss
    - Improving visibility in surgical field
  - Techniques:
    - Anesthetic depth, vasodilators, beta-blockers, fluid restriction
  - Supported by meta-analysis
    - Specific types of surgeries: Sinus, Orthopedics, Spine, Liver, Prostate
    - Based on small, low-quality, outdated studies
      - Safety not adequately assessed
  - Risks:
    - Organ hypoperfusion and injury

Anesthetic blood sparing techniques

- Controlled (permissive) hypotension
  - There is an association between hypotension and adverse outcomes



*Gregory et al. Anesth Analg 2021;132:1654-1665

Neuraxial Anesthesia (Epidural/Spinal)

- Mechanism:
  - Sympathetic blockade → reduced arterial pressure
    → reduced venous pressure
    → reduced surgical stress
      → stabilization of clotting factors
      → reduced fibrinolysis
  - Evidence:
    - Conflicting
      - Older, lower quality evidence positive
      - Newer, higher quality evidence negative

Acute normovolemic hemodilution

- Removal of 3-4 units of blood before surgery and simultaneous replacement with crystalloids or colloids
  - Theoretical example:
    - if Hct = 0.40 and EBL = 1L $\rightarrow$ RBC Loss = 400 cc
    - if Hct = 0.25 and EBL = 1L $\rightarrow$ RBC Loss = 250 cc
    - RBC conserved = 150 cc or $\sim$ 2/3 of a unit of PRBC
- Effectiveness questionable
  - Older, lower quality evidence
- Safety not properly assessed
  - Many things can go wrong
  - Patient left anemic for prolonged periods
    - Association between intraoperative anemia and adverse outcomes in some settings

Anesthetic blood sparing techniques / Permissive Hypotension/ Neuraxial anesthesia / ANH

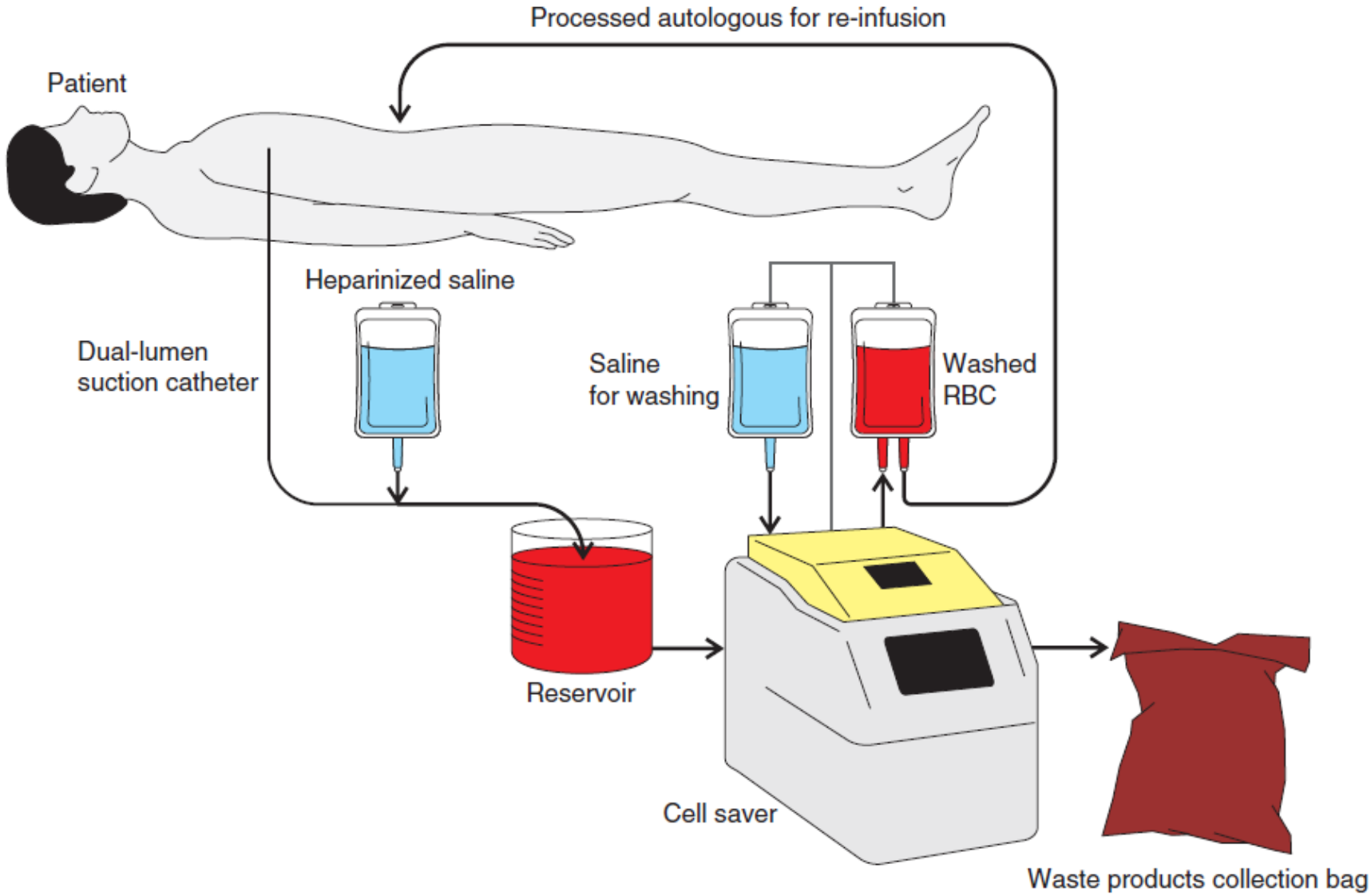
1. Has to be effective ?
2. Has to be at least as safe as transfusion ?
3. Costs should be reasonable ✓

Anesthetic blood sparing techniques / Permissive Hypotension/ Neuraxial anesthesia / ANH

- New versus old study dichotomy:
  - Surgical techniques have improved substantially
    - Faster, less invasive (e.g., prostate / orthopedics)
  - Clinical studies have gotten better

- Current status of anesthetic blood sparing techniques:
  - Modest benefit on blood loss and transfusion
  - Major benefit is improved visibility in surgical field
    - ↓ length of surgery + surgical control of bleeding = ↓ blood loss
  - Driving factor is surgical need rather than PBM

Cell Salvage



Cell Salvage

- Complications are rare
  - Hemolysis, air embolism, incomplete washing, infections
  - Washing removes: >90% viable RBCs, >90% washout; >95% Free Hb and albumin; goal is 55-80% Hct
  - Safer than allogeneic blood
    - Lower AE rates (0.027% versus 0.14%); Better quality (fresh versus old blood)
- Indications
  - High anticipated blood loss:
    - > 500-1000 mL; 10-20% of BV; 1-2 units of recovered RBC
  - Anemia, antibodies or rare blood types, JW
- Benefits
  - Reduce RBC exposure
    - On average, ↓0.7 units; ↑avoidance ~40%; More effective when massive bleeding

Ashworth et al. BJA 2010;105:401-416; Miquel et al. Surgeries 2022;3:44-63

Cell Salvage

- Safety Considerations
  - Dilutional coagulopathy
  - Bacterial contamination of recovered blood
    - Washing removes >80% of bacteria; Leukocyte depletion filter removes >99%
    - Transfuse within 6 hours of collection to avoid contamination
  - Transfusion of activated WBCs, platelets, clotting factors; Inflammation
    - Limit transfusion to no more than 15 units

Ashworth et al. BJA 2010;105:401-416; Miquel et al. Surgeries 2022;3:44-63

Cell Salvage

- Safety Considerations
  - Cancer surgery
    - Reinfused tumour cells do not have metastatic potential
    - Not contraindicated in cancer surgery, but general recommendation not established
    - LDF reduces tumour load, but slows infusion rates, becomes saturated and can cause bradykinin-mediated hypotension
  - PPH:
    - Contamination by bacteria, amniotic fluid, fetal red cells (isoimmunization)
    - Not cost-effective

Ashworth et al. BJA 2010;105:401-416; Miquel et al. Surgeries 2022;3:44-63

Cell Salvage

1. Has to be effective ✓
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Pharmacologic Agents

- Antifibrinolytics – Tranexamic acid
- Desmopressin (DDVP)
- Prothrombin complex concentrate (PCC); 3-factor vs. 4-factor
- Fibrinogen concentrate
- rFVIIa

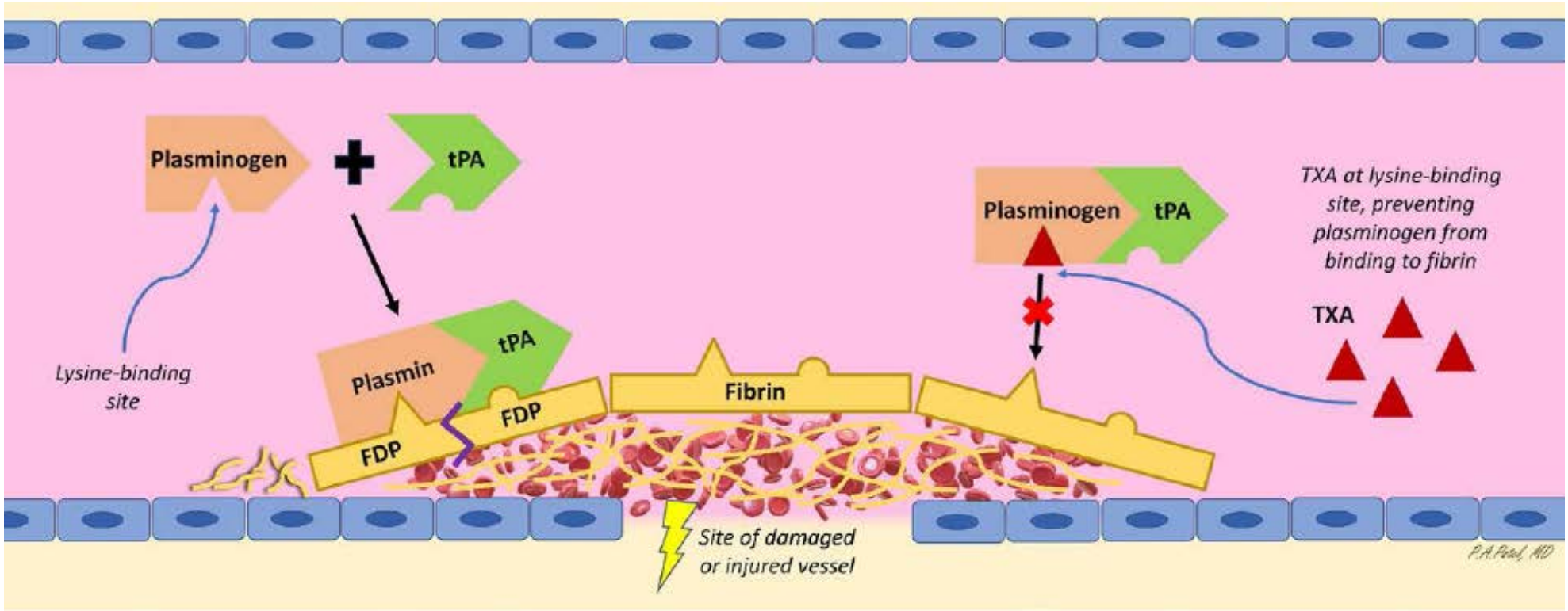
Tranexamic Acid

- Old (>50 years) drug
- On WHO list of essential medicines
- Almost all usage is still off-label in Canada
  - “Increased local fibrinolysis when the diagnosis is indicative of hyperfibrinolysis as in dental extraction in patients with coagulopathies (in conjunction with antihaemophilic factor).”

Patel et al. Anesth Analg 2022;135:460-73

Tranexamic Acid

- Clot stabilizer, not a clot activator



Patel et al. Anesth Analg 2022;135:460-73

Tranexamic Acid

- Hyperfibrinolysis is contributing factor to bleeding in surgery
- TA reduces bleeding in some, but not all settings
  - In the right settings, it reduces blood loss and transfusions by one-third
- Benefits > Risks … but not in all settings
  - Contraindications: Allergy, Hypercoagulable state
  - Renally excreted: dose adjustment
  - Cautions:
    - Seizure risk, renal failure, recent thromboembolic event, cirrhosis
- Dosage is not fully clarified
  - Recommendations based on specific clinical studies that were not fully based on pharmacokinetic considerations

Patel et al. Anesth Analg 2022;135:460-73

Tranexamic Acid

- Pharmacokinetics:
  - Therapeutic plasma concentration is ≈10 mg/L
  - 80% inhibition requires plasma concentration of 20 mg/L
  - 100% inhibition requires plasma concentration of 100 mg/L

  - 10 mg/kg IV (≈1g) → 10 mg/L in plasma (5-6 hours)
    - Good for most situations
  - 10 mg/kg IV + 1 mg/kg/hr → 30 mg/L in plasma
    - Good for high-risk situations such as cardiac surgery or if prolonged

Patel et al. Anesth Analg 2022;135:460-73; McCormack Drugs 2012;72:585-617

Trauma

Effects of tranexamic acid on death, vascular occlusive events, and blood transfusion in trauma patients with significant haemorrhage (CRASH-2): a randomised, placebo-controlled trial

*CRASH-2 trial collaborators**

- N = 20,211
- Dose: 1g bolus + 1g infusion over 8 hours
- Primary outcome: 28-day in-hospital all-cause mortality

CRASH-2 Collaborators Lancet 2010;376:23-32

Trauma

	Tranexamic acid (n=10 060)	Placebo (n=10 067)	RR (95% CI)	p value (two-sided)
Any cause of death	1463 (14·5%)	1613 (16·0%)	0·91 (0·85–0·97)	0·0035
Bleeding	489 (4·9%)	574 (5·7%)	0·85 (0·76–0·96)	0·0077
Vascular occlusion*	33 (0·3%)	48 (0·5%)	0·69 (0·44–1·07)	0·096
Multiorgan failure	209 (2·1%)	233 (2·3%)	0·90 (0·75–1·08)	0·25
Head injury	603 (6·0%)	621 (6·2%)	0·97 (0·87–1·08)	0·60
Other causes	129 (1·3%)	137 (1·4%)	0·94 (0·74–1·20)	0·63

Data are number (%), unless otherwise indicated. RR=relative risk. *Includes myocardial infarction, stroke, and pulmonary embolism.

Table 2: **Death by cause**

CRASH-2 Collaborators Lancet 2010;376:23-32

Trauma

	Tranexamic acid allocated	Placebo allocated	Risk ratio (95% CI)
Time to treatment (h)			
≤1	198/3747 (5·3%)	286/3704 (7·7%)	0·68 (0·57–0·82)
>1–3	147/3037 (4·8%)	184/2996 (6·1%)	0·79 (0·64–0·97)
>3	144/3272 (4·4%)	103/3362 (3·1%)	1·44 (1·12–1·84)
χ^2=23·516; p<0·0000			

	≤1 h (n=7451)	>1–3 h (n=6033)	>3 h (n=6634)
Continents			
Asia	1213 (16·3%)	2475 (41·0%)	3656 (55·1%)
Africa	2490 (33·4%)	1437 (23·8%)	872 (13·1%)
Central and South America	2453 (32·9%)	1456 (24·1%)	1355 (20·4%)
North America, Europe, and Oceania	1295 (17·4 %)	665 (11·0%)	751 (11·3%)

CRASH-2 Collaborators Lancet 2011;377:1096-101

Cardiac Surgery

Tranexamic Acid in Patients Undergoing Coronary-Artery Surgery

Paul S. Myles, M.P.H., M.D., Julian A. Smith, F.R.A.C.S., Andrew Forbes, Ph.D., Brendan Silbert, M.B., B.S., Mohandas Jayarajah, M.B., B.S.,

- N = 4631
- Dose: 100 mg/kg → seizures → 50 mg/kg
- Primary outcome: 30-day mortality + thromboembolic events

Myles et al. NEJM 2017;376:136-48

Cardiac Surgery

Outcome	TA (n = 2311)	Placebo (n = 2320)	Risk Ratio
Death or TE	16.7%	18.1%	0.92 (0.81 – 1.05)
Reoperation	1.4%	2.8%	0.49 (0.32 – 0.75)
Blood Product Tx	37.9%	54.7%	0.69 (P < 0.001)
Blood Product (Units)	3 (2-6)	4 (2-8)	P < 0.001
Seizures	0.7%	0.1%	7.62 (1.77 – 68.7)

Myles et al. NEJM 2017;376:136-48

Cardiac Surgery – High vs Low Dose

JAMA | Original Investigation

Effect of High- vs Low-Dose Tranexamic Acid Infusion on Need for Red Blood Cell Transfusion and Adverse Events in Patients Undergoing Cardiac Surgery

The OPTIMAL Randomized Clinical Trial

Jia Shi, MD; Chenghui Zhou, MD; Wei Pan, MD; Hansong Sun, MD; Sheng Liu, MD; Wei Feng, MD; Weijian Wang, MD; Zhaoyun Cheng, MD; Yang Wang, PhD; Zhe Zheng, MD; for the OPTIMAL Study Group

- N=3031
- High-dose ≈100 mg/kg vs Low-dose ≈ 20 mg/kg

Shi et al. JAMA 2022;328:336-347

Cardiac Surgery – High vs Low Dose

Table 2. Primary and Secondary Outcomes

Outcomes	High-dose tranexamic acid	Low-dose tranexamic acid	Estimate of difference (95% CI)	*P* value
Full analysis set, No.	1525	1506		
Primary efficacy end point				
Patients with red blood cell transfusion, No. (%)	333 (21.8)	391 (26.0)	−4.1 (−∞ to −1.1)[a]	.004
Adjusted for study site			−4.0 (−∞ to −1.0)[a]	.005
Primary safety end point				
30-d composite, No./total (%)	265/1502 (17.6)	249/1481 (16.8)	0.8 (−∞ to 3.9)[b]	.003
Adjusted for study site			0.9 (−∞ to 3.9)[b]	.004
Safety end-point components, No. (%)				
Clinical seizure[c]	15 (1.0)	6 (0.4)	0.6 (−0.0 to 1.2)	.05
Kidney dysfunction[d]	71 (4.7)	71 (4.7)	−0.1 (−1.6 to 1.5)	.94
Myocardial infarction[e]	172 (11.3)	167 (11.1)	0.2 (−2.1 to 2.5)	.87
Stroke[f]	10 (0.7)	8 (0.5)	0.1 (−0.5 to 0.7)	.66
Pulmonary embolism[g]	1 (0.1)	0	0.1 (−0.2 to 0.0)	>.99
Deep vein thrombosis[h]	15 (1.0)	12 (0.8)	0.2 (−0.5 to 0.9)	.58
Death[i]	9 (0.6)	10 (0.7)	−0.1 (−0.1 to 0.01)	.80

Shi et al. JAMA 2022;328:336-347

Non-Cardiac Surgery

Tranexamic Acid in Patients Undergoing Noncardiac Surgery

P.J. Devereaux, M. Marcucci, T.W. Painter, D. Conen, V. Lomivorotov,

- N=9535
- Non-cardiac surgery at-risk for bleeding but excluding neurosurgery or cases where physicians were planning on using tranexamic acid
- Dose: 1 g at start and 1g at end of surgery

Devereaux et al. NEJM 2022;386:1986-97

Non-Cardiac Surgery

Any procedure	4729/4757 (99.4)	4740/4778 (99.2)
General‡	1769/4729 (37.4)	1773/4740 (37.4)
Orthopedic	1083/4729 (22.9)	1063/4740 (22.4)
Vascular	699/4729 (14.8)	700/4740 (14.8)
Urologic	598/4729 (12.6)	624/4740 (13.2)
Spinal	237/4729 (5.0)	206/4740 (4.3)
Gynecologic	162/4729 (3.4)	171/4740 (3.6)
Thoracic	127/4729 (2.7)	146/4740 (3.1)
Low-risk	39/4729 (0.8)	34/4740 (0.7)
Plastic	14/4729 (0.3)	23/4740 (0.5)

Devereaux et al. NEJM 2022;386:1986-97

Non-Cardiac Surgery

Table 2. Effects of Tranexamic Acid on 30-Day Outcomes.*

Outcome	Tranexamic Acid (N=4757)	Placebo (N=4778)	Hazard Ratio (95% CI)†	P Value
Primary efficacy outcome: composite bleeding outcome — no. (%)‡	433 (9.1)	561 (11.7)	0.76 (0.67–0.87)	<0.001§
Individual components of composite bleeding outcome — no. (%)				
Life-threatening bleeding¶	78 (1.6)	79 (1.7)	0.99 (0.73–1.36)	
Major bleeding¶	363 (7.6)	496 (10.4)	0.72 (0.63–0.83)	
Bleeding into a critical organ¶	12 (0.3)	21 (0.4)	0.57 (0.28–1.16)	
Primary safety outcome: composite cardiovascular outcome — no./total no. (%)‖	649/4581 (14.2)	639/4601 (13.9)	1.02 (0.92–1.14)	0.04**
Individual components of composite cardiovascular outcome — no. (%)				
MINS¶	608 (12.8)	602 (12.6)	1.02 (0.91–1.14)	
Nonhemorrhagic stroke††	24 (0.5)	16 (0.3)	1.51 (0.80–2.84)	
Peripheral arterial thrombosis††	22 (0.5)	23 (0.5)	0.96 (0.53–1.72)	
Symptomatic proximal venous thromboembolism††	32 (0.7)	28 (0.6)	1.15 (0.69–1.91)	
Other secondary outcomes — no. (%)				
Bleeding independently associated with death after noncardiac surgery	416 (8.7)	541 (11.3)	0.76 (0.67–0.87)	
MINS not fulfilling the universal definition of myocardial infarction	549 (11.5)	549 (11.5)	1.01 (0.89–1.13)	
Myocardial infarction	67 (1.4)	53 (1.1)	1.27 (0.89–1.82)	
Net risk–benefit outcome‡‡	983 (20.7)	1046 (21.9)	0.94 (0.86–1.02)	

Devereaux et al. NEJM 2022;386:1986-97

GI Bleed

Effects of a high-dose 24-h infusion of tranexamic acid on death and thromboembolic events in patients with acute gastrointestinal bleeding (HALT-IT): an international randomised, double-blind, placebo-controlled trial

*The HALT-IT Trial Collaborators**

- N = 12,009
- Dose: 1 g + 3g/24 hours
- Primary outcome: 5-day bleeding mortality

HALT-IT Trial Collaborators Lancet 2020;395:1927-1936

GI Bleed

Outcome	TXA N=5994	Placebo N=6015	RR (95% CI)
Death due to bleeding within 5 d	3.7%	3.8%	0.99 (0.82-1.18)
Arterial TE (MI/CVA)	0.7%	0.8%	0.92 (0.60-1.39)
Venous TE* Seizures	0.8% 0.6%	0.4% 0.4%	1.85 (1.15-2.98) 1.73 (1.03-2.93)
Transfusion	68.5%	69.1%	0.99 (0.97-1.02)

*higher in variceal bleed or liver disease

HALT-IT Trial Collaborators Lancet 2020;395:1927-1936

Tranexamic Acid

1. Has to be effective ✓
2. Has to be at least as safe as transfusion ✓
3. Costs should be reasonable ✓

Tranexamic Acid – Summary

- NICE: Offer to adults for all surgical procedures with moderate (>500 mL) blood loss

Tranexamic Acid – Summary

- NICE: Offer to adults for all surgical procedures with moderate (>500 mL) blood loss

Table 1. Typical Dosing Regimens for Perioperative TXA Administration

Setting	Typical TXA dosing regimen[a]	Notes
Adult cardiac surgery[10,11]	10–30 mg/kg IV loading dose; then 2–16 mg/kg/h infusion; ±1–2 mg/kg for pump prime	Target plasma concentrations 20–100 µg/mL (depending on desired degree of fibrinolysis inhibition)[b]
Obstetrics[8]	1 g IV over 10 min; can repeat 1-g IV if bleeding persists after 30 min	Recommended to give within first 3 h of birth
Acute trauma[6,12]	1 g IV over 10 min; then 1 g infused over 4–8 h	Recommended to give within first 3 h of injury (ideally within first hour)
Orthopedic surgery[13,14]	10–20 mg/kg IV in single or divided doses (or 1–3 g topical dose)	Target plasma concentration ≥10 µg/mL
Neurosurgery[15]	10 mg/kg IV loading dose; then 0.5–2 mg/kg/h infusion	
Pediatric surgery[16]	10–30 mg/kg IV loading dose; then 5–10 mg/kg/h infusion	Maximum loading dose 2 g; target plasma concentrations between 20 and 70 µg/mL[b]
Pediatric cardiac surgery[16–18]	30 mg/kg (age <12 mo) or 10 mg/kg (age ≥12 mo) IV loading dose; then 10 mg/kg/h infusion; ±addition to pump prime for concentration of 60 µg/mL	Maximum loading dose 2 g; intermediate target plasma concentration 60 µg/mL (lower target concentration of 20 µg/mL or higher target concentration of 150 µg/mL requires dosage scheme adjustment)[b]

Patel et al. Anesth Analg 2022;135:460-472

Tranexamic Acid – Summary

- A more pragmatic approach considering POISE-3:

High risk of bleeding or developing excessive bleeding

↓

Consider Administering

↓

10 mg/kg bolus ± 1 mg/kg/hour or equivalent

Restrictive Transfusion Threshold

JAMA | Special Communication

Patient Blood Management Recommendations From the 2018 Frankfurt Consensus Conference

Markus M. Mueller, MD; Hans Van Remoortel, PhD; Patrick Meybohm, MD, PhD; Kari Aranko, MD, PhD; Cécile Aubron, MD, PhD; Reinhard Burger, PhD; Jeffrey L. Carson, MD, PhD; Klaus Cichutek, PhD; Emmy De Buck, PhD; Dana Devine, PhD; Dean Fergusson, PhD; Gilles Folléa, MD, PhD; Craig French, MB, BS; Kathrine P. Frey, MD; Richard Gammon, MD; Jerrold H. Levy, MD; Michael F. Murphy, MD, MBBS; Yves Ozier, MD; Katerina Pavenski, MD; Cynthia So-Osman, MD, PhD; Pierre Tiberghien, MD, PhD; Jimmy Volmink, DPhil; Jonathan H. Waters, MD; Erica M. Wood, MB, BS; Erhard Seifried, MD, PhD; for the ICC PBM Frankfurt 2018 Group

Mueller et al. JAMA 2019;321:983-997

Restrictive Transfusion Threshold

Table 2. Clinical Recommendations: Red Blood Cell Transfusion Thresholds

Clinical Recommendation	Level of Evidence
CR5—Restrictive RBC transfusion threshold (hemoglobin concentration <7 g/dL) in critically ill but clinically stable intensive care patients	Strong recommendation, moderate certainty in the evidence of effects
CR6—Restrictive RBC transfusion threshold (hemoglobin concentration <7.5 g/dL) in patients undergoing cardiac surgery	Strong recommendation, moderate certainty in the evidence of effects
CR7—Restrictive transfusion threshold (hemoglobin concentration <8 g/dL) in patients with hip fracture and cardiovascular disease or other risk factors	Conditional recommendation, moderate certainty in the evidence of effects
CR8—Restrictive transfusion threshold (hemoglobin concentration 7-8 g/dL) in hemodynamically stable patients with acute gastrointestinal bleeding	Conditional recommendation, low certainty in the evidence of effects

Abbreviations: CR, clinical recommendation; RBC, red blood cell.

- Editorial (Zeller, Kaufman)
  - Thresholds are ‘particularly specific’
  - If sole consideration for transfusion is the Hb level, then a restrictive threshold should be used

Mueller et al. JAMA 2019;321:983-997

Restrictive Transfusion Threshold

Restrictive or Liberal Red-Cell Transfusion for Cardiac Surgery

C.D. Mazer, R.P. Whitlock, D.A. Fergusson, J. Hall, E. Belley-Cote, K. Connolly, B. Khanykin, A.J. Gregory, É. de Médicis, S. McGuinness, A. Royse, F.M. Carrier, P.J. Young, J.C. Villar, H.P. Grocott, M.D. Seeberger, S. Fremes, F. Lellouche, S. Syed, K. Byrne, S.M. Bagshaw, N.C. Hwang, C. Mehta, T.W. Painter, C. Royse, S. Verma, G.M.T. Hare, A. Cohen, K.E. Thorpe, P. Jüni, and N. Shehata, for the TRICS Investigators and Perioperative Anesthesia Clinical Trials Group*

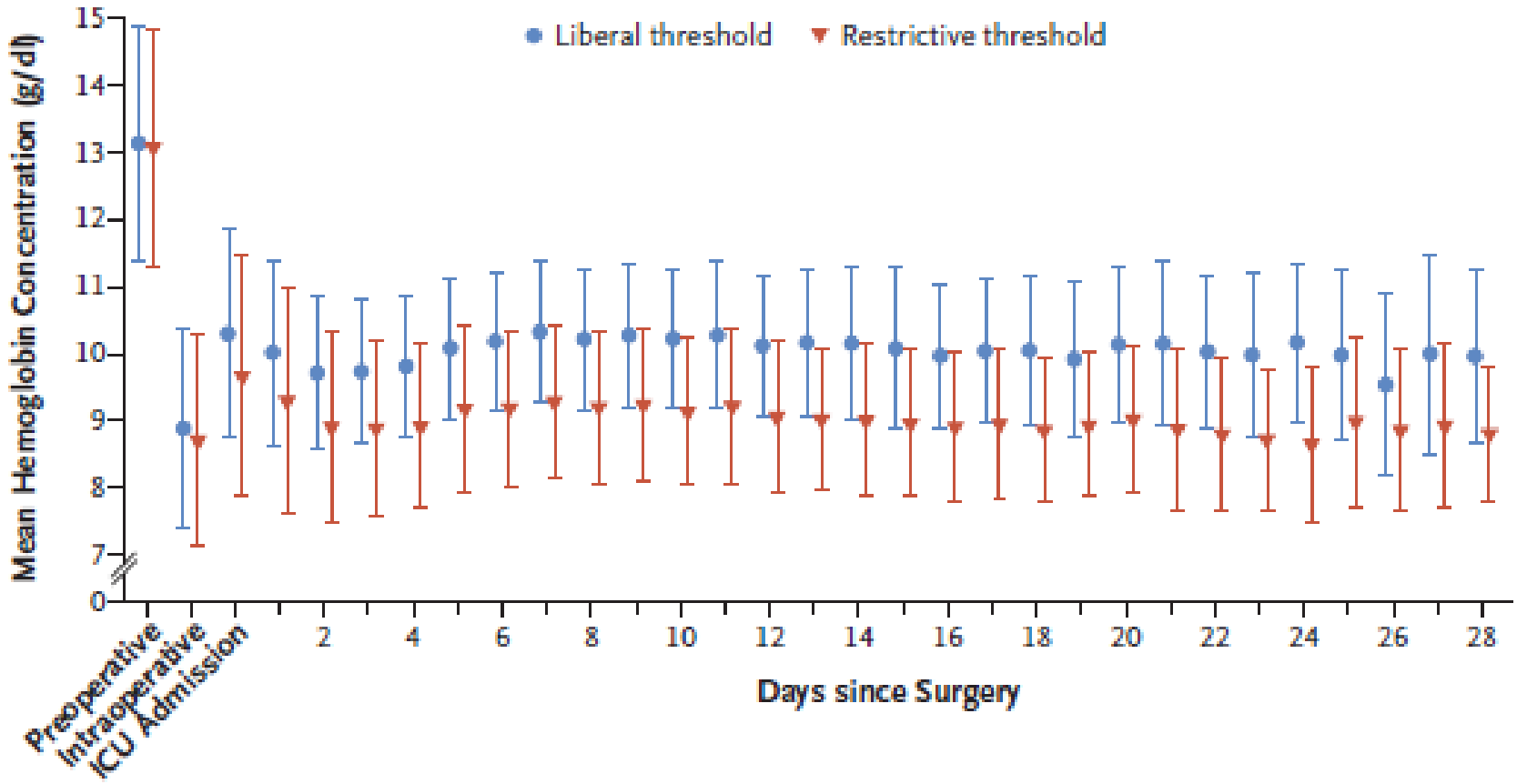
Mazer et al. NEJM 2017;377:2133-44

Restrictive Transfusion Threshold

- Higher-risk cardiac surgery
- Randomized before surgery
- Restrictive group:
  - Transfuse if Hb < 75 g/L
- Liberal group:
  - Transfuse if Hb < 95 g/L during surgery/ICU stay
  - Transfuse if Hb < 85 g/L on ward
- Protocol suspended if rapid bleeding or hemodynamic instability due to bleeding

Mazer et al. NEJM 2017;377:2133-44

Restrictive Transfusion Threshold

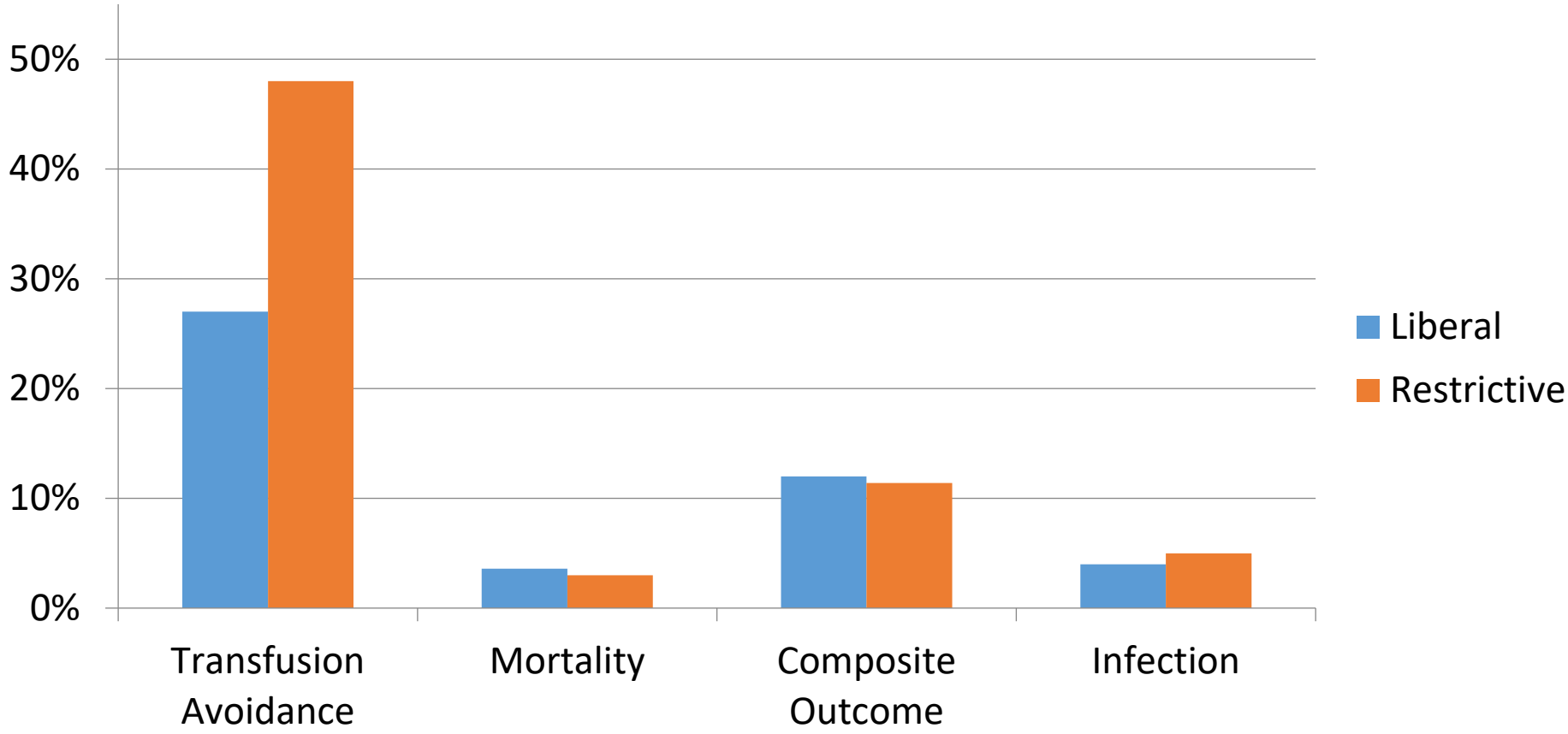


No. at Risk

Liberal threshold	2428	2435	2015	1354	731	443	327	233	153	122	112	76	69	57	51
Restrictive threshold	2429	2454	2007	1431	841	527	376	305	215	165	131	117	91	77	76

Mazer et al. NEJM 2017;377:2133-44

Restrictive Transfusion Threshold



Mazer et al. NEJM 2017;377:2133-44

Restrictive Transfusion Threshold

1. Has to be effective ✓
2. Has to be at least as safe as transfusion ✓
3. Costs should be reasonable ✓

Restrictive Transfusion Threshold

- Caveat
  - For the most part, studies have included non-bleeding, euvolemic, stable patients without heart disease, and have studied fixed transfusion thresholds
- Surgical patients, however, may be:
  - Bleeding and coagulopathic
  - Unstable and hypovolemic
  - Critically ill with limited organ reserve

- Transfusion decision more complicated than just measuring Hb level

Optimizing Coagulation

- Point-of-care guided coagulation management algorithms
  - Whole-blood based assays
    - Viscoelastic
      - ROTEM, TEG
    - Platelet function
      - Multiple assays available

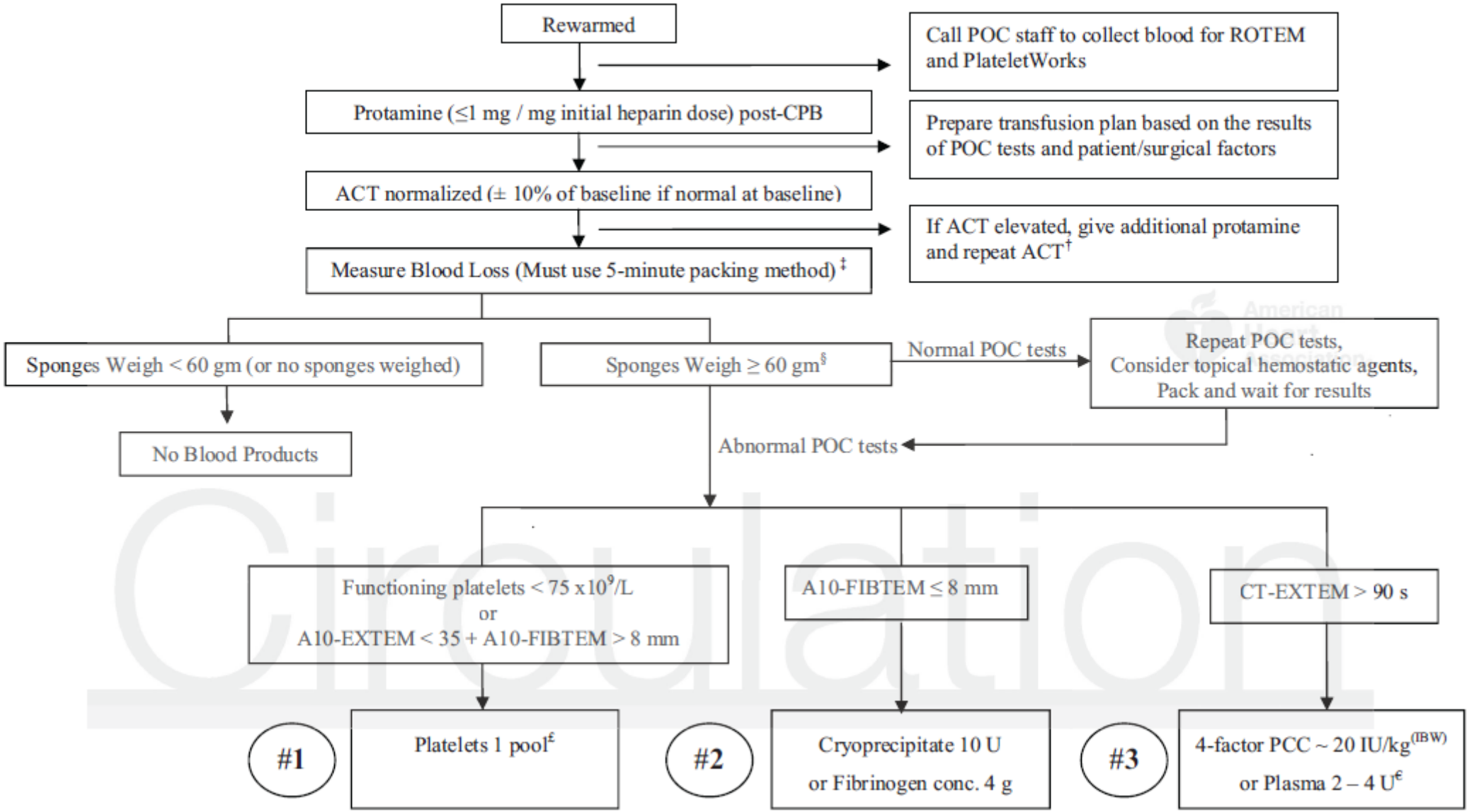
Point-of-Care Hemostatic Testing in Cardiac Surgery

A Stepped-Wedge Clustered Randomized Controlled Trial

Keyvan Karkouti, MD
Jeannie Callum, MD
Duminda N. Wijeysundera, MD, PhD
Vivek Rao, MD, PhD
Mark Crowther, MD
Hilary P. Grocott, MD
Ruxandra Pinto, PhD
Damon C. Scales, MD, PhD
TACS Investigators

Karkouti et al. Circulation 2016;134:1152-1162

Cardiac Surgery Blood Transfusion Algorithm*



Karkouti et al. Circulation 2016;134:1152-1162

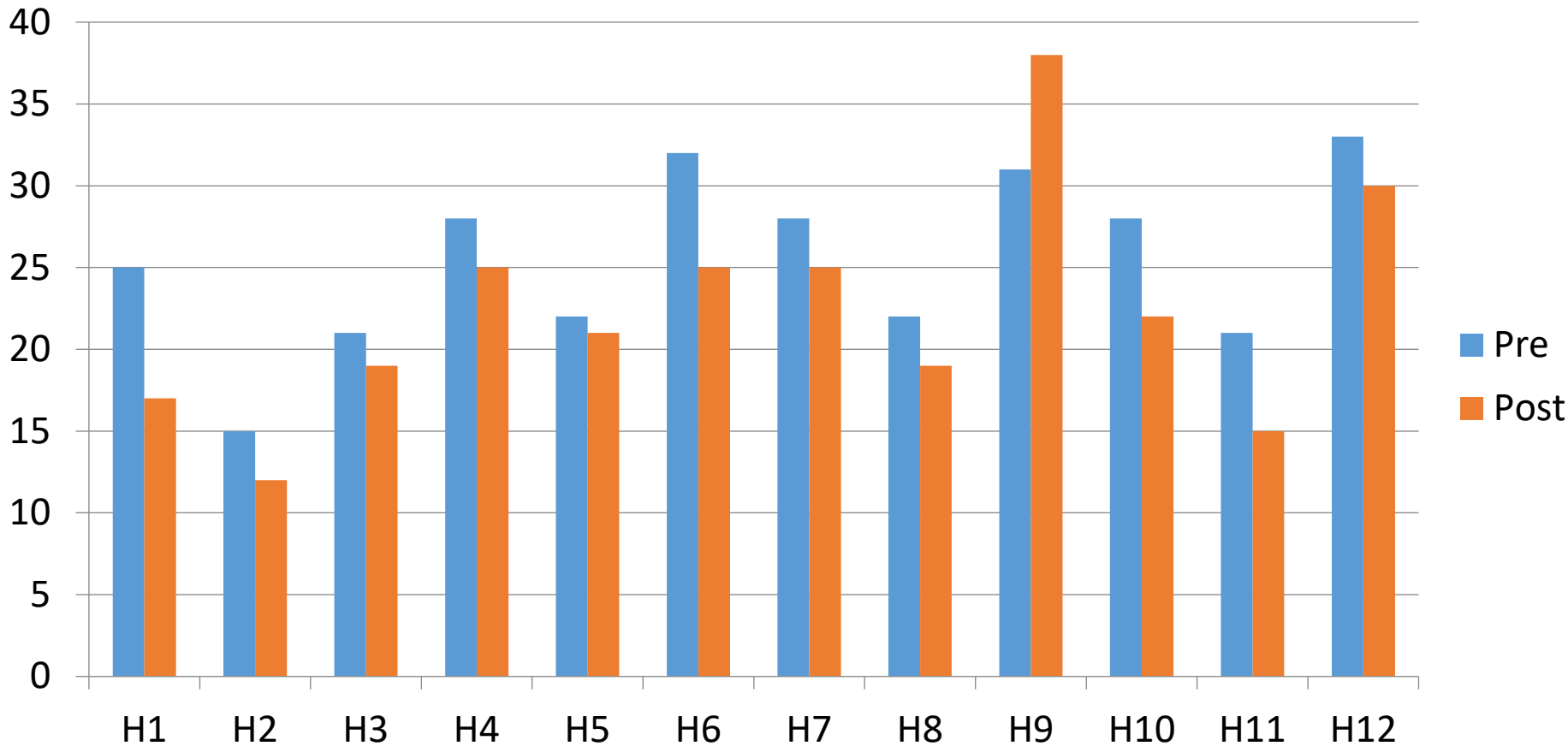
Results

- 7402 patients in the study
  - Control phase n = 3555; Intervention phase n = 3847

Outcome	Incidence
RBC	45%
Platelet	25%
Plasma	22%
Cryoprecipitate	5%
Major Bleeding	24%
Major Complications	10%

Karkouti et al. Circulation 2016;134:1152-1162

Major Bleeding



Karkouti et al. Circulation 2016;134:1152-1162

Results

Outcome	Relative Risk Reduction
RBC	0.91 (0.85 – 0.98); P = 0.02; NNT = 24.7
Platelet	0.77 (0.68 – 0.87); P < 0.001; NNT = 16.7
Plasma	NC
Cryoprecipitate	NC
Major Bleeding	0.83 (0.72 – 0.94); P = 0.004; NNT = 22.6
Adverse Outcomes	NC
Processes of Care	NC

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Optimizing Coagulation

1. Has to be effective ✓
2. Has to be at least as safe as transfusion ✓
3. Costs should be reasonable ✓

Summary of Intraoperative PBM

Procedure	Recommendation
Minimize Blood Loss	
Anesthetic blood sparing techniques	+
Acute normovolemic hemodilution	-
Cell salvage	+++
Pharmacological therapies – i.e., Tranexamic acid	+++
POC-based coagulation management algorithm	+++
Manage Anemia	
Improve tolerance of anemia	+
Evidence-based transfusion thresholds – i.e., restrictive	+++

Recent PBM Update

GUIDELINE TITLE STS/SCA/AmSECT/SABM Update to the Clinical Practice Guidelines on Patient Blood Management

RELEASE DATE June 30, 2021

PRIOR VERSIONS 2011 (update), 2007

DEVELOPER Society of Thoracic Surgeons (STS), Society of Cardiovascular Anesthesiologists (SCA), American Society of ExtraCorporeal Technology (AmSECT), and Society for the Advancement of Blood Management (SABM)

TARGET POPULATION Adult cardiothoracic and other high-risk surgical patients

MAJOR RECOMMENDATIONS

- Use of synthetic antifibrinolytic agents such as ε-aminocaproic acid or tranexamic acid is indicated for blood conservation in surgery (strong recommendation; strong evidence).
- A restrictive perioperative allogeneic packed red blood cell transfusion strategy is preferred over a liberal strategy to conserve blood (strong recommendation; strong evidence).
- Goal-directed transfusion algorithms incorporating point-of-care testing are recommended to reduce periprocedural bleeding and transfusion (strong recommendation; moderate evidence).
- For elective cases, ticagrelor should be withdrawn preoperatively for a minimum of 3 days, clopidogrel for 5 days, and prasugrel for 7 days (strong recommendation; moderate evidence).

Hameed et al. JAMA 2022;327:578-579

Thank you