Postoperative bleeding is one of the most common complications following cardiothoracic surgical procedures requiring cardiopulmonary bypass (CPB). Treatment strategies for postoperative bleeding include supportive care with volume resuscitation, the administration of blood products, pharmacologic intervention, and surgical reexploration. Massive hemorrhage requiring surgical reexploration occurs in about 6% of the patients and is associated with considerable morbidity and mortality.1,2 Surgical reexploration due to excessive bleeding has been associated with a threefold to fourfold increase in mortality and with multiple morbidities, including renal failure, sepsis, atrial arrhythmias, prolonged mechanical ventilatory support, and increased length of hospital stay.3 Thus, safe and effective strategies to prevent and treat postoperative bleeding are crucial.

LIMITATIONS OF CURRENTLY AVAILABLE PHARMACOLOGIC AGENTS

Blood products are often used to correct the anemia that ensues and to promote hemostasis. Fresh-frozen plasma, pooled platelets, and cryoprecipitates replenish clotting factors and other important mediators of the clotting cascade, and are helpful in restoring hemostasis. However, the administration of blood products in this setting has several limitations, including a relatively high rate of trans-
fusion-related reactions and adverse effects as well as the potential for disease transmission. Consequently, various pharmacologic agents are used to achieve hemostasis in this setting, including protamine, aprotinin, aminocaproic acid, tranexamic acid, and desmopressin. Protamine effectively reverses the effects of heparin but is associated with several adverse effects, including hypotension, hypersensitivity reactions, and paradoxical anticoagulation with excessive doses. Aprotinin is a serine protease inhibitor with potent antifibrinolytic effects and is often administered prophylactically to prevent bleeding complications in patients having vascular surgery. However, routine prophylaxis is very costly, and aprotinin has been associated with hypersensitivity reactions, particularly with repeated exposure. Aminocaproic acid and tranexamic acid are lysine analogues that bind to the lysine-binding site on plasminogen, inhibiting the conversion of plasminogen to plasmin and effectively inhibiting fibrinolysis. However, when the administration of these drugs is delayed until after open heart surgery, they are of limited benefit compared to prophylactic administration perioperatively. Last, desmopressin increases the release of von Willebrand factor from endothelial cells and increases the circulating levels of factor VIII, leading to more effective hemostasis. However, many patients with severe postoperative bleeding are unresponsive to these drugs.

MECHANISM OF ACTION OF RECOMBINANT ACTIVATED FACTOR VII

Recombinant activated factor VII (rFVIIa) is a clotting factor that is commonly used to treat bleeding disorders in patients with acquired hemophilia. Because rFVIIa can initiate coagulation independent of factors VIII and IX, it is useful as treatment in patients with hemophilia A or B complicated by high-responding inhibitors. Coagulation is triggered locally at the site of vascular injury as rFVIIa binds with tissue factor, and activates factors IX and X to their active forms (ie, IXα and Xα), ultimately leading to thrombin generation and clot formation. Given its local effects at the site of vascular injury, rFVIIa may have a role in achieving hemostasis in patients experiencing refractory postoperative bleeding complications.

RATIONALE FOR USE OF rFVIIa

The risk of serious postoperative bleeding complications for patients requiring CPB during cardiothoracic surgical procedures remains high. In these patients, not only is morbidity and mortality increased, but also health-care utilization and costs are higher. Postoperative bleeding in this setting is associated with an increased length of stay, increased use of blood products, and increased use of hemostatic agents to control bleeding. Consequently, postoperative bleeding incurs an average incremental cost of $3,866. In cases of refractory postoperative hemorrhaging requiring surgical reexploration, mortality is more than sevenfold higher (15.4%) and the additional cost is nearly $10,000.

Although the prophylactic use of hemostatic agents such as aminocaproic acid, tranexamic acid, and aprotinin are effective in reducing bleeding and the need for the transfusion of blood products, treatment options are limited when serious postoperative bleeding occurs. Since rFVIIa triggers hemostasis locally at the site of the vascular injury, it has a role in the management of patients with intractable bleeding. Its use as a hemostatic agent in nonhemophilic patients has been described in several cases of severe hemorrhage from disseminated intravascular coagulation, as well as refractory postoperative bleeding following spinal fusion surgery, total hip arthroplasty, major abdominal surgery, pelvic surgery, neurosurgery, and hysterectomy.

PERSONAL EXPERIENCE

Our experience with rFVIIa in this setup consists of two patients (Table 1). Both patients had vasculopathies that were associated with Marfan syndrome. One patient presented with a chronic enlarging thoracoabdominal dissecting aneurysm, and the other with an ascending aortic root aneurysm. The first case was considerably more complex as the extent of aortic dissection extended from the distal aortic root to the infrarenal aorta and was complicated by dense adhesions from two prior surgeries. This patient experienced profound hemorrhaging (estimated blood loss, approximately 50 L) postoperatively that was refractory to a massive administration of blood products (approximately 140 U) and hemostatic drugs perioperatively. The use of rFVIIa (120 μg/kg) had a dramatic effect on hemostasis. Within minutes of administration, the chest tube output decreased from nearly 1 L/h to < 100 mL/h (Fig 1, top, A). The need for blood products was substantially decreased (ie, only 1 U packed RBCs was necessary in the 10 h following administration), hemodynamics were stabilized, and surgical reexploration was avoided. The second patient who had been given rFVIIa following the repair of an aortic root aneurysm using hypothermic circulatory arrest had a more gradual response to the drug, despite repeated doses (Fig 1, bottom, B). Eventually, hemostasis was achieved after
<table>
<thead>
<tr>
<th>Study/Year</th>
<th>Age/Gender</th>
<th>Surgery</th>
<th>Interventions to Achieve Hemostasis Prior to rFVIIa</th>
<th>Blood Products Used Prior to rFVIIa</th>
<th>rFVIIa Dose, μg/kg</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aldouri et al16/2000</td>
<td>2.5 yr/M</td>
<td>Arterial switch operation, atrial septal defect closure, pulmonary artery construction</td>
<td>None within 48 h</td>
<td>PRBCs, Plts, 1 U; FFP, 1 U; EBL, 4.5 L</td>
<td>30</td>
<td>Rapid hemostasis and correction of coagulopathy within 1 h; blood loss at 4 h, 85 mL total</td>
</tr>
<tr>
<td>73 yr/F</td>
<td>MVR, tricuspid valve repair</td>
<td>Surgical re-exploration, none within 48 h</td>
<td>Conventional blood products</td>
<td>30</td>
<td>Rapid hemostasis and correction of coagulopathy within 1 h; blood loss decreased from 900 to &lt; 50 mL/h</td>
<td></td>
</tr>
<tr>
<td>48 yr/F</td>
<td>MVR, AVR, RVAD, intraaortic balloon pump</td>
<td>Surgical re-exploration, none within 48 h</td>
<td>Conventional blood products</td>
<td>30</td>
<td>Rapid hemostasis and correction of coagulopathy within 1 h; blood loss decreased from 300 to &lt; 100 mL/h; patient died on POD 3 due to heart failure</td>
<td></td>
</tr>
<tr>
<td>66 yr/M</td>
<td>AVR, aortic root replacement</td>
<td>None within 48 h</td>
<td>Conventional blood products; EBL, 5 L</td>
<td>30</td>
<td>Rapid hemostasis and correction of coagulopathy within 1 h; blood loss decreased to &lt; 70 mL/h allowing patient to come off CPB and chest closure to proceed</td>
<td></td>
</tr>
<tr>
<td>48 yr/M</td>
<td>MVR, right aorta-ventricular fistula repair</td>
<td>None within 48 h</td>
<td>Conventional blood products; EBL, 8 L</td>
<td>30</td>
<td>Blood loss decreased to 300 mL in first postoperative hour and was negligible at 4 h; rapid correction of coagulopathy within 30 min</td>
<td></td>
</tr>
<tr>
<td>Hendriks et al17/2001</td>
<td>65 yr/M</td>
<td>Mitral and tricuspid valve repair</td>
<td>Protamine, aprotinin, tranexamic acid, surgical reexploration × 2</td>
<td>PRBCs, 30 U; Plts, 30 U; FFP, 20 U</td>
<td>90</td>
<td>Rapid hemostasis and correction of coagulopathy; good recovery</td>
</tr>
<tr>
<td>Potapov et al18/2002</td>
<td>57 yr/F</td>
<td>BiVAD placement</td>
<td>Protamine, aprotinin, desmopressin, antithrombin III</td>
<td>PRBCs, 30 U; Plts, 4 U; FFP, 56 U</td>
<td>120 × 1</td>
<td>Bleeding decreased from &gt; 1 L/h to 500 mL/h after first dose of rFVIIa; bleeding decreased to &lt; 100 mL/h within 2 h of second rFVIIa dose, allowing closure of chest</td>
</tr>
<tr>
<td>von Heymann et al19/2002</td>
<td>65 yr/M</td>
<td>Redo CABG</td>
<td>Aprotinin, desmopressin, surgical reexploration</td>
<td>PRBCs, 9 U; Plts, 1 U; FFP, 6 U</td>
<td>50 × 2</td>
<td>Hourly chest tube output decreased by 50% after first rFVIIa dose and was reduced to 40 mL/h immediately after second dose 2 h later; patient extubated on POD 8 and discharged from ICU on POD 10</td>
</tr>
<tr>
<td>Kastrup et al20/2002</td>
<td>26 yr/M</td>
<td>AVR</td>
<td>Aprotinin</td>
<td>PRBCs, 3 U; Plts, 2 U; FFP, 4 U</td>
<td>40</td>
<td>Rapid hemostasis, cardiac enzyme levels were elevated on POD 1, necessitating emergent cardiac catheterization but no coronary pathology was identified; patient discharged from ICU on POD 2</td>
</tr>
</tbody>
</table>
Table 1—Continued

<table>
<thead>
<tr>
<th>Study/Year</th>
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<tr>
<td>Bui et al(^{21})/2002</td>
<td>56 yr/M</td>
<td>Repeat lung transplant requiring CPB and ECMO</td>
<td>Protamine, surgical reexploration, APCCs</td>
<td>Continued transfusion of blood components</td>
<td>90 × 1, 55 × 1</td>
<td>Gradual hemostasis after each dose of rFVIIa, but bleeding persisted at a rate of approximately 300 mL/h necessitating administration of APCCs; several minutes into the APCC infusion patient developed cardiogenic shock and expired 20 min later from suspected massive intracardiac and ECMO thromboses</td>
</tr>
<tr>
<td>Naik et al(^{22})/2003</td>
<td>75 yr/F</td>
<td>Bioprosthetic AVR and supracoronary ascending aorta replacement</td>
<td>Protamine, desmopressin, aprotinin, surgical reexploration × 2</td>
<td>PRBCs, 14 U; Plts, 15 U; FFP, 21 U</td>
<td>107</td>
<td>Bleeding decreased from 400–500 mL/h in preceding 11 h to only approximately 40 mL/h over next 12 h; patient was discharged home on POD 17</td>
</tr>
<tr>
<td>Tanaka et al(^{23})/2003</td>
<td>74 yr/F</td>
<td>MVR; Jehovah’s witness</td>
<td>Protamine, aprotinin, surgical repair of left atriotomy tear</td>
<td>Cell saver</td>
<td>45</td>
<td>Rapid hemostasis and correction of coagulopathy allowing chest closure; postoperative bleeding: 200 mL at 4 h, 740 mL at 24 h; patient required prolonged ventilatory support but was discharged from the ICU on POD 20</td>
</tr>
<tr>
<td>49 yr/M</td>
<td>MVR; Jehovah’s witness</td>
<td>Protamine, aprotinin</td>
<td>None</td>
<td>60</td>
<td>Rapid hemostasis within 3 min, allowing chest closure; coagulopathy also improved; postoperative bleeding: 270 mL upon ICU arrival, decreased to approximately 55 mL/h, total of 1,090 mL at 24 h; patient discharged from ICU on POD 4</td>
<td></td>
</tr>
<tr>
<td>Tobias et al(^{24})/2003</td>
<td>4 mo/F</td>
<td>ASD repair</td>
<td>Protamine</td>
<td>Cryo, 2 U</td>
<td>70</td>
<td>Rapid hemostasis and correction of coagulopathy; rFVIIa repeated on POD 7 to rapidly correct recurrent coagulopathy prior to removal of transthoracic pulmonary artery catheter; patient discharged home on POD 21</td>
</tr>
<tr>
<td>Leibovitch et al(^{25})/2003</td>
<td>10 wk/F</td>
<td>AV canal repair</td>
<td>Tranexamic acid, protamine</td>
<td>PRBCs, Plts, FFP</td>
<td>100 × 4 doses</td>
<td>Gradual hemostasis achieved, no additional blood products required; patient discharged from ICU on POD 4, discharged home on POD 7</td>
</tr>
<tr>
<td>Wahlgren and Swedenborg(^{26})/2003</td>
<td>62 yr/M</td>
<td>AAA repair</td>
<td>Protamine, tranexamic acid</td>
<td>PRBCs, 16 U, Plts, FFP, 22 U</td>
<td>80</td>
<td>Rapid hemostasis; discharged to rehabilitation facility after lengthy hospital course</td>
</tr>
<tr>
<td>Lucey and Myburgh(^{27})/2003</td>
<td>15 yr/M</td>
<td>Bilateral lung transplant</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>Rapid hemostasis; cardiac tamponade developed due to large mediastinal thrombosis requiring surgical evacuation</td>
</tr>
</tbody>
</table>

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Three doses of rFVIIa were given and therapy with aminocaproic acid was initiated. Surgical reexploration was also avoided in this patient.
patients who developed thromboembolic events hemorrhaged following lung transplantation. One patient was believed to have experienced massive intracardiac and extracorporeal membrane oxygenation circuit thromboses following the administration of both rFVIIa and activated prothrombin complex concentrates; this patient developed cardiac arrest and died. The other patient developed cardiac tamponade requiring surgical intervention to evacuate a large mediastinal thrombosis following rFVIIa administration. In the third patient, cardiac enzyme levels were elevated on postoperative day 1, and coronary thrombosis

![Graph A](image1)

![Graph B](image2)

**Figure 1.** Preoperative chest tube (CT) drainage before and after administration of factor VIIa in two patients (top, A, and bottom, B) who underwent aortic operations. OR = operating room.
was suspected, but coronary angiography failed to reveal any coronary pathology.  

The other concern regarding the use of rFVIIa in nonhemophilic patients experiencing severe postoperative bleeding complications is cost. The acquisition cost for a 1.2-mg vial of rFVIIa is $1,480.32. When considering the use of rFVIIa in this setting, the cost of the drug must be weighed against the costs of nondrug therapy, including the administration of blood products and surgery. Given the high costs and adverse outcomes associated with the administration of blood products and surgical reexploration for bleeding complications, the administration of rFVIIa may be a cost-effective treatment strategy in certain instances.

Conclusions

Serious bleeding complications following cardiopulmonary bypass surgery remain troublesome. Effective treatment strategies are lacking. Although the successful use of rFVIIa in such instances has been reported in 20 patients to date, its use in this setting has not been studied in a controlled clinical trial. Therefore, the safety and efficacy of rFVIIa for the treatment of bleeding complications following cardiopulmonary bypass surgery requires CPB cannot be fully elucidated until it has been evaluated formally in a clinical trial. Nevertheless, anecdotal reports have suggested that it is effective in achieving rapid hemostasis. For patients with postoperative bleeding that is refractory to blood product administration and hemostatic drugs, therapy with rFVIIa may be considered as a treatment option. Although the dose of rFVIIa is truly unknown, an initial dose of approximately 60 µg/kg may be appropriate. If hemostasis is not achieved within 30 to 60 min, consideration may be given to a second dose; however, the cost-effectiveness of repeated dosing is questionable given the limited number of experiences reported to date.

References

10. Tobias JD. Synthetic factor VIIa to treat diaphragmatic coagulopathy during posterior spinal fusion in two children. Anesthesiology 2002; 96:1522–1523