Recombinant Activated Coagulation Factor VII and Prothrombin Complex Concentrates Are Equally Effective in Reducing Hematoma Volume in Experimental Warfarin-Associated Intracerebral Hemorrhage

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Background and Purpose—Based on an experimental model of warfarin-associated intracerebral hemorrhage, we investigated whether the rapid reversal of anticoagulation using prothrombin complex concentrates (PCC) or recombinant activated coagulation factor VII (rFVIIa) reduces hematoma volume.

Methods—Mice were orally pretreated with warfarin (2 mg/kg). Intracerebral hemorrhage was induced by collagenase injection into the right striatum. Forty-five minutes later, PCC (100 IE/kg), rFVIIa (1 mg/kg), or an equal volume of saline was administered intravenously. Hematoma volume after 24 hours was quantified using a photometric hemoglobin assay.

Results—International normalized ratio was 4.3 ± 0.4 in saline-treated mice, 0.9 ± 0.1 in rFVIIa mice, and 1.4 ± 0.2 in PCC mice. Intracerebral hemorrhage volume was 29.0 ± 19.7 μL in the saline group (n = 7), 8.6 ± 4.3 μL in the rFVIIa group (n = 6), and 6.1 ± 1.8 μL in the PCC group (n = 7; analysis of variance between-group differences P < 0.004; post hoc rFVIIa versus saline P = 0.021; PCC versus saline P = 0.007). No significant difference was found between PCC- and rFVIIa-treated animals.

Conclusions—Our results suggest that PCC and rFVIIa are equally effective in restoring coagulation and preventing excessive hematoma growth in acute warfarin-associated intracerebral hemorrhage. (Stroke. 2011;42:00-00.)

Key Words: animal models □ anticoagulation □ ICH □ intracerebral hemorrhage □ warfarin

Intracerebral hemorrhage (ICH) occurring during warfarin anticoagulation is a severe subtype of stroke with a short-term mortality rate of approximately 50%. Current therapeutic practice is to rapidly restore coagulation using either prothrombin complex concentrates (PCC) or recombinant activated FVII (rFVIIa). Whereas PCC substitutes all 4 vitamin K-dependent coagulation factors that are diminished by warfarin therapy, rFVIIa boosts coagulation by directly activating factor X on the surface of activated platelets. Despite these mechanistic differences, both substances have been shown to be effective in rapidly and completely reversing anticoagulation in clinical studies as demonstrated by correcting the prothrombin time and its derived measure, the international normalized ratio (INR). However, therapeutic effectiveness of PCC and rFVIIa in terms of reducing hematoma size and improving functional outcome remains undetermined. Recently, an experimental study suggested that rFVIIa may be inferior to PCC regarding the restoration of coagulation and the prevention of hematoma growth in ICH induced during warfarin anticoagulation. We addressed this question in our well-established mouse model of anticoagulation-associated ICH.

Methods

Experimental Procedures
Male CD-1 mice (Charles River Laboratories, Wilmington, MA) aged 12 to 16 weeks were used. Warfarin (2 mg/kg body weight) was administered orally through drinking water according to a previously established protocol. In this anticoagulation model, INR values reach the therapeutic range used in humans after a 24-hour feeding period. After warfarin withdrawal, INR values remain within the therapeutic range for 6 hours. The plasma activity of all 4 vitamin K-dependent coagulation factors is decreased, indicating full warfarin anticoagulation.

First, we compared the effects of PCC (n = 5), rFVIIa (n = 6), and saline (n = 3) application, respectively, on INR and coagulation factor...
Activity of the vitamin K-dependent coagulation factors II, VII, IX, and X, measured with human factor deficient plasma. As compared with untreated controls, warfarin anticoagulation led to a drop in activity of all 4 factors. rFVIIa therapy resulted in an increase in factor VII activity, PCC application modestly increased the activity of all 4 coagulation factors. Data are presented as mean±SEM; rFVIIa indicates recombinant activated coagulation factor VII; PCC, prothrombin complex concentrates.

Figure 1. INR values in untreated controls (control; n=3) and in anticoagulated mice that received saline (W+saline; n=3), rFVIIa (W+rFVIIa; n=6), or PCC (W+PCC; n=5), respectively. INR values are represented as box and whiskers plots. By definition, the box indicates the 25th and 75th percentile of the distribution and the whiskers the 10th and 90th percentile, respectively. INR indicates international normalized ratio; rFVIIa, recombinant activated coagulation factor VII; PCC, prothrombin complex concentrates.

Results
Anticoagulated mice that received a saline injection had a mean INR of 4.3±0.4. INR values were significantly reduced after the administration of rFVIIa (0.9±0.1) compared with anticoagulated mice treated with saline. PCC therapy also lowered INR values (1.4±0.2; analysis of variance between-group differences P<0.001; post hoc rFVIIa versus saline P<0.001; PCC versus saline P<0.001; Figure 1). Nonanticoagulated control mice had a mean INR of 0.9±0.1. The activity of all 4 vitamin K-dependent coagulation factors was found decreased after warfarin feeding, indicating full warfarin anticoagulation (Figure 2). rFVIIa application in anticoagulated mice increased the activity level of factor VII, whereas the other factors remained largely unchanged. PCC application modestly increased the activity of all 4 coagulation factors.

Warfarin-treated mice had significantly larger hematoma volumes 24 hours after ICH induction as compared with nonanticoagulated controls (21.7±14.3 μL versus 8.5±2.9 μL; P=0.034; Figure 3A). Mortality was 4 of 7 mice in the anticoagulated group and 0 of 7 in the nonanticoagulated control group.

Mean ICH volume in anticoagulated mice that received saline 45 minutes after ICH induction was 29.0±19.7 μL. Both mice treated with rFVIIa and PCC showed markedly reduced hematoma volumes compared with anticoagulated mice treated with saline (rFVIIa: 8.6±4.3 μL, PCC: 6.1±1.8 μL; analysis of variance between-group differences P=0.004; post hoc rFVIIa versus saline P=0.021; PCC versus saline P=0.007). No significant difference in terms of ICH volume was found between animals that were treated with rFVIIa or PCC (P=1.000; Figure 3B). In the saline-
treated group, 2 of 7 animals died. There was no mortality in the rFVIIa or the PCC group.

Discussion

Our in vivo data suggest that the coagulation activation by rFVIIa administration and the anticoagulation reversal by PCC therapy are similarly effective in reducing INR values and preventing excessive hematoma growth in a mouse model of warfarin-associated ICH.

As for PCC therapy, the substitution of concentrated amounts of the vitamin K-dependent coagulation factors appears to be a meaningful approach to reverse warfarin anticoagulation. Clinical studies reported rapid normalization of INR values in anticoagulated patients after bolus injection of PCC. There is also evidence that the administration of PCC is capable of limiting the expansion of warfarin-related ICH. In a pathophysiologically different way, rFVIIa boosts coagulation by directly activating factor X on the surface of activated platelets without the need for FVIII and FIX. This leads to thrombin generation and to the formation of a stable clot at the site of injury. rFVIIa is highly effective in rapidly reversing warfarin anticoagulation in terms of correcting the INR.

In contrast, a recently published experimental study reported rFVIIa to be not capable of normalizing INR values or preventing extensive hematoma growth as compared with nonanticoagulated controls. This study used a different method for inducing ICH and may explain the divergent results. The reasons for the divergent results are not entirely clear but are most likely related to medication, dosing, or application issues. The INR with some prothrombin time reagents does not correct as much as others after administration of rFVIIa; thus, one possibility is that the point-of-care INR device used in the other study was not as responsive to rFVIIa as the laboratory INR used in our study. However, this would not entirely explain the different effectiveness of rFVII in terms of reducing hematoma growth. In our study, INR values were determined in a reference group and not in the actual mice that underwent ICH induction due to the lethal amount of blood that had to be collected for INR determination in the clinical laboratory. This makes a direct comparison of INR values and ICH volume impossible. Nevertheless, our model has been shown to reliably establish effective warfarin anticoagulation.

In summary, our results suggest that both PCC and rFVIIa are potent treatment options for anticoagulated patients with ICH, but human studies would be needed to confirm these findings.

Disclosures

None.

References


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