Studies have shown that antifibrinolytic (aprotinin, tranexamic acid, or e-aminocaproic acid) reduce blood loss in orthopedic surgery. However, most lacked sufficient power to evaluate the efficacy and safety on clinical outcomes. This meta-analysis aims to evaluate whether intravenous antifibrinolytics, when compared with placebo, reduce perioperative allogeneic erythrocyte transfusion requirement in adults undergoing orthopedic surgery and whether it might increase the risk of venous thromboembolism. From MEDLINE, EMBASE, and the Cochrane Controlled Trials Register, the authors identified 43 randomized controlled trials in total hip and knee arthroplasty, spine fusion, musculoskeletal sepsis, or tumor surgery performed to July 2005 (for aprotinin, 23 trials with 1,268 participants; tranexamic acid, 20 with 1,084; e-aminocaproic acid, 4 with 171). Aprotinin and tranexamic acid reduced significantly the proportion of patients requiring allogeneic erythrocyte transfusion according to a transfusion protocol. The odds ratio was 0.43 (95% confidence interval, 0.28–0.64) for aprotinin and 0.17 (0.11–0.24) for tranexamic acid. Results suggest a dose–effect relation with tranexamic acid. e-Aminocaproic acid was not efficacious. Unfortunately, data were too limited for any conclusions regarding safety. Although the results suggest that aprotinin and tranexamic acid significantly reduce allogeneic erythrocyte transfusion, further evaluation of safety is required before recommending the use of antifibrinolytics in orthopedic surgery.

This article is accompanied by an Editorial View. Please see: Weiskopf RB. If you prick us, do we not bleed? Anesthesiology 2006; 105:873–6.

Materials and Methods

Literature Search

An exhaustive literature search, both manual and computer assisted (MEDLINE, EMBASE, and Cochrane Con-
trolled Trials Register), was conducted to identify all randomized studies performed to the end of July 2005 comparing an intravenous prophylactic antifibrinolytic regimen (aprotinin, tranexamic acid, or EACA) with no treatment, placebo, or such regimen. Orthopedic surgery was defined as surgery for primary hip arthroplasty, primary knee arthroplasty, and major orthopedic procedures, which included revision or bilateral arthroplasty, spinal fusion or posterior spinal fixation, musculoskeletal sepsis, or musculoskeletal tumors. Only the key words aprotinin, tranexamic acid, and ε-aminocaproic acid were used. All identified articles were analyzed unless it was clear from the summary that the study was not performed in an orthopedic setting. There was no restriction on the language of the article. Abstracts of meetings were searched, and reference lists in reviews, studies, and previous meta-analyses were checked. Particular attention was paid to duplicate reports; when studies were published as an abstract and an original article, only the latter was considered. When more than one article was available from a single study, an attempt was made to extract the information required from all relevant publications.

**Study Selection**

From these articles, open-label and single- or double-blind randomized studies evaluating an antifibrinolytic agent were selected. Only studies with a control group, either untreated or treated with a placebo or another antifibrinolytic agent, were considered. Studies that included another method in addition to antifibrinolytic administration for reducing allogeneic blood transfusion were eligible for selection if this other method was used in both the active and control groups. To be selected, studies also had to have evaluated the efficacy and/or safety of the antifibrinolytic using at least one of the following endpoints: proportion of patients receiving at least one unit of allogeneic erythrocyte transfusion according to a transfusion protocol, proportion of patients receiving any kind of erythrocyte transfusion (i.e., comprising allogeneic and/or preoperative autologous blood donation and/or cell salvage blood) according to a transfusion protocol, number of units of allogeneic blood transfused per patient according to a transfusion protocol, total volume of blood loss in milliliters (perioperative and postoperative), venous thromboembolism documented by an objective test (ultrasound, fibrinogen uptake test, or venography for deep venous thrombosis, ventilation-perfusion lung scanning, pulmonary angiography, or spiral computed tomography for pulmonary embolism), or arterial thrombosis (myocardial infarction, stroke, or limb ischemia).

To limit evaluation bias on transfusion criteria, it was considered necessary that selected studies had to have a transfusion protocol that defined at which point a transfusion of allogeneic and/or autologous erythrocytes was considered necessary. The protocol had to be identical across treatment arms within a study but could differ between studies. Trials that lacked or did not mention the use of a transfusion policy meeting these requirements were not considered for the analyses of the proportion of patients requiring erythrocyte transfusion. For example, no trials were selected where autologous blood was systematically reinfused, whatever the value of hemoglobin or the hematocrit.

Studies were excluded if they were not or were not clearly stated to have been randomized. Studies conducted in pediatric patients were also excluded. Dose-ranging studies without a control group or no treatment for comparison were excluded.

Predefined data from individual trials were initially extracted independently by two authors (F.M., P.Z.). In the event of a discrepancy with regard to either study selection or data extraction, the decision of a third author (S.M.) was final. The authors of the selected trials were contacted to confirm the accuracy of the extracted data and/or to supply missing information or clarification. When more than one active treatment group was compared with a single control group (e.g., dose-ranging studies), the experimental groups were combined and then compared collectively with the control group.**

**Statistical Analysis**

The results from each trial were summarized on an intention-to-treat basis.

For binary outcomes such as the proportion of patients requiring allogeneic or any kind of erythrocyte transfusion or having postoperative venous thromboembolism, the meta-analyses were performed using various methods, namely, logarithm of the relative risk, logarithm of the odds ratio (OR), and rate difference. Association and heterogeneity tests were performed for each meta-analysis. A value of $P \leq 0.05$ in an association test and a value of $P \leq 0.10$ in a heterogeneity test were considered to be statistically significant. For each binary outcome, the method with the lowest heterogeneity is presented. In the absence of a clear explanation for heterogeneity, a random-effects model was planned. The results of these meta-analyses are presented with 95% confidence intervals. The meta-analysis was performed according to the drug (aprotinin, tranexamic acid, and EACA).

Sensitivity analyses were conducted to explore the robustness of the results. We first examined the effect of the study design by separating double-blind studies (primary analysis) from open-label studies (secondary analysis). To identify any study that may have exerted a disproportionate influence on the summary treatment effect, we deleted studies one at a time. When trials

presented a per-protocol analysis, a sensitivity analysis imputed the missing data by choosing the worst-case scenario for treatment. We checked for publication bias using the funnel plot technique. In the absence of major bias suggesting that the study quality of one or a subgroup of studies may have exaggerated the treatment effect, all studies were combined. Then, exploratory analyses were performed according to the type of surgery (primary hip or knee arthroplasty vs. major orthopedic surgery), the type of anesthesia, the dose regimen, and the number of bolus doses (single vs. continuous infusion or repeated boluses).

To assess the transfusion risk with the use of antifibrinolytics according to the underlying transfusion risk, i.e., how the transfusion rate in the antifibrinolytic group varies when the rate in the control group increases, an effect model analysis was performed using a weighted linear regression. The transfusion risk was defined as the proportion of patients receiving at least one unit of allogeneic erythrocyte transfusion according to a transfusion protocol within a trial. A value of \( P < 0.05 \) was considered as statistically significant when testing the slope of the linear regression.

For continuous outcomes such as number of units of allogeneic blood transfused per patient and total volume of blood loss in milliliters, the meta-analyses were performed using a random-effects model of the standardized mean difference. The mean number of units of allogeneic blood transfused per patient or total volume of blood loss of each group (treated and control group), and the corresponding SDs were collected for each trial. For each continuous outcome, standardized mean difference was calculated as the mean difference between groups divided by the common within-group SD and adjusted according to the weight of individual studies. Methods for the meta-analysis of continuous data assume that data are normally distributed. It follows that conclusions based on outcomes that are not normally distributed may be erroneous. Measures were taken to avoid this: When analyzing continuous outcomes, trials were not considered if they did not summarize normal data, i.e., trials having skewed distribution with an SD larger than the mean. When median and range were reported rather than mean and SD, assumptions were made to estimate these values: The median was designated as the mean, and the SD was estimated as \((0.95 \times \text{range})/4\). The results of the standardized mean difference from these meta-analyses are presented with 95% confidence intervals. A value of \( P \leq 0.05 \) in an association test was considered to be statistically significant.

Meta-analyses were performed using the software Comprehensive Meta Analysis (Biostat, Englewood, NJ), whereas linear regressions were calculated using the software S-PLUS 2000 (MathSoft, Seattle, WA).

### Results

#### Study Selection

The literature search identified 762 studies, 63 of which remained potentially relevant after reading through titles and abstracts. Articles were excluded for several reasons: uncertainty regarding randomization (2 articles),10,11 lack of a control group (3),12-14 duplication (3),15-17 subgroup analysis of previous study (1),18 anti-fibrinolytic not administered intravenously (1),19 conducted in pediatric patients (5),20-24 All trialists were contacted; 23 confirmed the accuracy of the extracted data or supplied missing information (see acknowledgments). However, 5 studies were further withdrawn because data were not available on any outcome.25-29 Therefore, 43 trials were selected for analysis: 23 with aprotinin,30-52 20 with tranexamic acid47,53-71 and 4 with EACA48,50,52,72; 4 trials studied two different antifibrinolytics compared with placebo.47,48,50,52

#### Study Design

Tables 1 to 3 show the design of the studies.

**Aprotinin.** Twenty-three studies using aprotinin and comprising a total of 1,268 patients were selected.30-52 Trials were small; only 2 randomized more than 100 patients. Nine involved major orthopedic surgery (revision or bilateral arthroplasty, spinal fusion or posterior spinal fixation, musculoskeletal sepsis, or musculoskeletal tumor surgery), 12 involved primary hip arthroplasty, and 2 involved knee arthroplasty. In each study, patients received a loading dose of aprotinin before surgery, which was followed by continuous infusion or repeated boluses in 17 studies. The mean total perioperative dose of aprotinin was variable but was lower than 4 million kallikrein inactivator units in all except 2 studies.49,50 Fifteen studies reported the use of a transfusion protocol but did not comment on the extent to which these protocols were followed. The transfusion trigger threshold differed between trials. Prophylaxis of deep venous thrombosis, where described, varied between studies according to the country and the year of the study. Venous thrombosis screening was done by an objective test in 8 studies.51,54,55,59,45,49,50,52 Type of anesthesia varied between trails. Finally, 14 of the 22 studies were double-blind, and one open study reported a proper generation of the treatment allocation sequences (random number-generated table).48

**Tranexamic Acid.** Twenty-two studies using tranexamic acid and comprising a total of 1,084 patients were selected.37,55-71 As with aprotinin, trials were small, and only one randomized more than 100 patients. Trials only involved primary hip or knee arthroplasty (10 and 11, respectively). Mean total perioperative dose of tranexamic acid was variable and ranged from 10 to 135 mg/kg. In hip arthroplasty,
<table>
<thead>
<tr>
<th>Reference</th>
<th>Year</th>
<th>Type of Surgery</th>
<th>Aprotinin and Intravenous Dose</th>
<th>Transfusion Protocol of Erythrocyte Units</th>
<th>DVT Prophylaxis</th>
<th>Screening of DVT</th>
<th>Type of Anesthesia</th>
<th>Double-blind</th>
<th>Patients Randomized</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wenner10</td>
<td>1982</td>
<td>THA</td>
<td>0.02 million KIU/kg</td>
<td>NA</td>
<td>UFH</td>
<td>Clinical</td>
<td>NA</td>
<td>No</td>
<td>32</td>
</tr>
<tr>
<td>Hatz13</td>
<td>1985</td>
<td>THA</td>
<td>1.5 million KIU</td>
<td>NA</td>
<td>UHF-DHE</td>
<td>FUT</td>
<td>MA</td>
<td>NA</td>
<td>120</td>
</tr>
<tr>
<td>Janssens32</td>
<td>1994</td>
<td>THA</td>
<td>2 million KIU + 0.5 million</td>
<td>KIU/h during surgery</td>
<td>LMWH</td>
<td>Clinical</td>
<td>GA</td>
<td>Yes</td>
<td>40</td>
</tr>
<tr>
<td>Thorpe33</td>
<td>1994</td>
<td>TKA</td>
<td>0.5 million KIU + 0.5 million</td>
<td>Depending on patient’s condition</td>
<td>UFH</td>
<td>NA</td>
<td>GA</td>
<td>No</td>
<td>17</td>
</tr>
<tr>
<td>Murkin44</td>
<td>1995</td>
<td>Complex</td>
<td>2 million KIU + 0.5 million</td>
<td>Hb &lt; 8 g/dl or blood loss &gt; 15% of blood volume</td>
<td>Warfarin or UHF</td>
<td>Ultrasound</td>
<td>GA</td>
<td>Yes</td>
<td>53</td>
</tr>
<tr>
<td>Hayes55</td>
<td>1996</td>
<td>THA</td>
<td>2 million KIU</td>
<td>Blood loss &gt; maximum tolerated blood loss</td>
<td>LMWH</td>
<td>Venography</td>
<td>RA</td>
<td>Yes</td>
<td>40</td>
</tr>
<tr>
<td>Llau36</td>
<td>1996</td>
<td>Spine</td>
<td>2 million KIU + 2 bolus of</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>Yes</td>
<td>20</td>
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<tr>
<td>Compostella37</td>
<td>1997</td>
<td>THA</td>
<td>2 million KIU + 0.5 million</td>
<td>KIU/h during surgery</td>
<td>Hb &lt; 27%</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>100</td>
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<tr>
<td>Utada38</td>
<td>1997</td>
<td>THA</td>
<td>2 million KIU</td>
<td>NA</td>
<td>Hb &lt; 25%</td>
<td>NA</td>
<td>NA</td>
<td>RA and GA</td>
<td>21</td>
</tr>
<tr>
<td>Capdevilla39</td>
<td>1998</td>
<td>MOS</td>
<td>1 million KIU + 0.5 million</td>
<td>Intravenous UHF</td>
<td>Ultrasound</td>
<td>GA</td>
<td>Yes</td>
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</tr>
<tr>
<td>Garcia-Enguita42</td>
<td>1998</td>
<td>Complex</td>
<td>2 million KIU + 0.5 million</td>
<td>Defined prospectively</td>
<td>NA</td>
<td>NA</td>
<td>RA</td>
<td>No</td>
<td>30</td>
</tr>
<tr>
<td>Llau41</td>
<td>1998</td>
<td>THA</td>
<td>2 million KIU</td>
<td>Hb &lt; 9 g/dl</td>
<td>LMWH</td>
<td>Clinical</td>
<td>GA</td>
<td>No</td>
<td>20</td>
</tr>
<tr>
<td>D’Ambrosio42</td>
<td>1999</td>
<td>THA</td>
<td>0.5 million KIU + 0.5 million</td>
<td>CS systematically reinfused</td>
<td>LMWH</td>
<td>Clinical</td>
<td>RA or GA</td>
<td>Yes</td>
<td>60</td>
</tr>
<tr>
<td>Lentschener43</td>
<td>1999</td>
<td>Spine</td>
<td>2 million KIU + 0.5 million</td>
<td>Hb &lt; 26%</td>
<td>LMWH</td>
<td>Clinical</td>
<td>GA</td>
<td>Yes</td>
<td>72</td>
</tr>
<tr>
<td>Langdown46</td>
<td>2000</td>
<td>THA</td>
<td>1.5 million KIU</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>Yes</td>
<td>60</td>
</tr>
<tr>
<td>Murkin55</td>
<td>2000</td>
<td>THA</td>
<td>0.5 million KIU or 1 million</td>
<td>Ht &lt; 18%</td>
<td>Warfarin</td>
<td>Ultrasound</td>
<td>RA</td>
<td>Yes</td>
<td>301</td>
</tr>
<tr>
<td>Cvauchovec48</td>
<td>2001</td>
<td>THA</td>
<td>1 million KIU + 1 million</td>
<td>Hb &lt; 9-10 g/dl</td>
<td>LMWH</td>
<td>Clinical</td>
<td>RA or GA</td>
<td>No</td>
<td>42</td>
</tr>
<tr>
<td>Engel47</td>
<td>2001</td>
<td>TKA</td>
<td>1 million KIU before</td>
<td>Hb &lt; 10 g/dl</td>
<td>LMWH</td>
<td>Clinical</td>
<td>RA</td>
<td>No</td>
<td>24</td>
</tr>
<tr>
<td>Urban48</td>
<td>2001</td>
<td>Spine</td>
<td>1 million KIU + 0.25 million</td>
<td>Hb &lt; 8 g/dl or Ht &lt; 25%</td>
<td>NA</td>
<td>Clinical</td>
<td>GA</td>
<td>No</td>
<td>40</td>
</tr>
<tr>
<td>Samama49</td>
<td>2002</td>
<td>MOS</td>
<td>4 million KIU + 1 million</td>
<td>Ht &lt; 24%</td>
<td>LMWH</td>
<td>Venography</td>
<td>GA</td>
<td>Yes</td>
<td>58</td>
</tr>
<tr>
<td>Amar50</td>
<td>2003</td>
<td>Cancer</td>
<td>2 million KIU + 0.5 million</td>
<td>Hb &lt; 8 g/dl or Ht &lt; 24%</td>
<td>IPC</td>
<td>Ultrasound</td>
<td>GA</td>
<td>Yes</td>
<td>47</td>
</tr>
<tr>
<td>Jeserschek51</td>
<td>2003</td>
<td>MOS</td>
<td>1 million KIU + 0.5 million</td>
<td>Ht &lt; 25–30%</td>
<td>LMWH</td>
<td>Clinical</td>
<td>NA</td>
<td>Yes</td>
<td>18</td>
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<tr>
<td>Ray52</td>
<td>2005</td>
<td>THA</td>
<td>2 million KIU + 0.5 million</td>
<td>Depending on patient’s condition</td>
<td>FPC + aspirin</td>
<td>Ultrasound</td>
<td>GA</td>
<td>Yes</td>
<td>30</td>
</tr>
</tbody>
</table>

First dose of aprotinin was started before surgery, otherwise stated. Trials that systematically reinfused autologous blood, whatever the value of hemoglobin (Hb) or hematocrit (Ht) was, were not considered to have used a transfusion protocol.

Complex THA = revision or bilateral primary total hip arthroplasty; CS = cell salvage surgery; DHE = dihydroergotamine; Double-blind = patients and investigators were blinded to treatment allocation; DVT = deep vein thrombosis; FPC = foot pump compression; FUT = fibrinogen uptake test; GA = general anesthesia; IPC = intermittent pneumatic compression; KIU = kallikrein inactivator units; LMWH = low-molecular-weight heparin; MOS = major orthopedic surgery such as revision arthroplasty, musculoskeletal sepsis, or tumors; NA = data not available; RA = regional anesthesia; Spine = spine fusion or posterior spinal fixation surgery; THA = total hip arthroplasty; TKA = total knee arthroplasty; UFH = unfractionated heparin.

ANTIFIBRINOLYTICS IN ORTHOPEDICS: META-ANALYSIS

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The loading dose was followed by a continuous infusion or repeated boluses in 14 studies; in most cases, the second bolus was 3 h later. The transfusion trigger threshold varied between trials and was reported in 15 of them. As with aprotinin, the authors did not comment on the extent to which the transfusion protocols were followed. Short-term prophylaxis of deep venous thrombosis usually comprised low-molecular-weight heparin or unfractionated heparin; LMWH = low-molecular-weight heparin; NA = data not available; PAD = preoperative autologous blood donation; RA = regional anesthesia.

The first dose of tranexamic acid was started before surgery in total knee arthroplasty (TKA) and before deflation of tourniquet in total knee arthroplasty (TKA), otherwise stated. Trials that systematically reinfused autologous blood, whatever the value of hemoglobin (Hb) or hematocrit (Ht) was, were not considered to have used a transfusion protocol.

Double-blind = patients and investigators were blinded to treatment allocation; DVT = deep vein thrombosis; GA = general anesthesia; IPC = intermittent pneumatic compression; LMWH = low-molecular-weight heparin; NA = data not available; PAD = preoperative autologous blood donation; RA = regional anesthesia.
bosis with low-molecular-weight heparin was the most common form of prophylaxis. Venous thrombosis screening was done by an objective test in 6 studies. The majority of trials were performed in Scandinavia; therefore, regional anesthesia (epidural or spinal anesthesia) was favored over general anesthesia. Finally, 14 of the 20 studies were double-blind, 5 open studies reported a proper generation of the treatment allocation sequences (computer-generated randomization table), and 3 open studies reported a proper concealment of the treatment allocation.

**α-Aminocaproic Acid**

There were only four selected studies using EACA, comprising a total of 171 patients. Two involved hip arthroplasty, and two involved major orthopedic surgery. All studies used a single bolus before surgery followed by a continuous infusion. Transfusion of erythrocytes was predefined by a transfusion protocol in three studies. In one study, the regimen of deep venous prophylaxis was unavailable. Venous thrombosis screening was done by an objective test in two studies. Three studies were double-blind, and the open study reported a proper generation of the treatment allocation sequences (random number-generated table).

**Results Regarding Requirement for Transfusion of Allogeneic Erythrocytes**

Lack of a transfusion protocol, as defined in the Materials and Methods section, was the reason for excluding eight studies from the evaluation of this criterion (three with aprotinin, four with tranexamic acid, and one with EACA). The other reason was nonavailable data of this criterion (five trials with aprotinin and nonavailable data on the use of a transfusion protocol (five with aprotinin and nonavailable data of this criterion (five trials with aprotinin).

We used the logarithm of the OR instead of the logarithm of the relative risk or the rate difference because it was the more conservative method. Treatment with aprotinin and tranexamic acid led to a significant reduction in the proportion of patients requiring at least one unit of allogeneic erythrocyte transfusion according to a transfusion protocol. Results were significant in double-blind studies for aprotinin (OR, 0.42 [95% confidence interval, 0.27–0.66]; P < 0.01) and for tranexamic acid (OR, 0.18 [0.12–0.28]; P < 0.01) (fig. 1). EACA did not lead to a significant reduction in the proportion of patients requiring allogeneic erythrocyte transfusion: The OR was 0.71 (0.29–1.73; P = 0.45; fig. 1).

Sensitivity analyses were not suggestive of major bias. Similar estimates of treatment effect for aprotinin and tranexamic acid were achieved in open-label studies: Heterogeneity test between open and double-blind subgroups was P = 0.92 for aprotinin and P = 0.22 for tranexamic acid (fig. 1). Deletion of individual studies one at a time did not significantly alter the primary outcome. After contacting the authors, data of excluded patients were unavailable in three per-protocol studies. Imputing these missing data by choosing the worst-case scenario for treatment did not modify the direction or magnitude of treatment effect. Funnel plots for each drug did not suggest that low-quality studies (open-label studies) and/or publication bias (absence of studies showing no significant beneficial effect) exaggerated the magnitude of the estimated treatment effect (fig. 2).

Because these sensitivity analyses did not suggest major bias due to study quality, open-label and double-blind studies were pooled. The pooled estimate revealed a statistically significant reduction in allogeneic erythrocyte transfusion for aprotinin compared with placebo (OR, 0.43 [0.28–0.64]; P < 0.01) and for tranexamic acid compared with placebo (OR, 0.17 [0.11–0.24]; P < 0.01; fig. 1).

Table 3. α-Aminocaproic Acid versus Placebo or No Treatment: Description of Studies

<table>
<thead>
<tr>
<th>Reference Year</th>
<th>Type of Surgery</th>
<th>EACA and Intravenous Dose</th>
<th>Transfusion Protocol of Erythrocyte Units</th>
<th>DVT Prophylaxis</th>
<th>Screening of DVT</th>
<th>Type of Anesthesia</th>
<th>Double-blind</th>
<th>Patients Randomized</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban 2001 Spine</td>
<td>5 g + 15 mg · kg⁻¹ · h⁻¹ during surgery</td>
<td>Hb &lt; 8 g/dl or Ht &lt; 25%</td>
<td>NA</td>
<td>Clinical</td>
<td>GA</td>
<td>No</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>Harley 2002 THA</td>
<td>150 mg/kg + 12.5 mg · kg⁻¹ · h⁻¹ for 5 h</td>
<td>Hb &lt; 8 g/dl or Ht &lt; 24%</td>
<td>UFH until INR &gt; 2 with warfarin</td>
<td>Clinical</td>
<td>RA and/ or GA</td>
<td>Yes</td>
<td>55</td>
<td></td>
</tr>
<tr>
<td>Amar 2003 Cancer</td>
<td>150 mg/kg + 15 mg · kg⁻¹ · h⁻¹ during surgery</td>
<td>Hb &lt; 8 g/dl or Ht &lt; 24%</td>
<td>IPC</td>
<td>Ultrasound</td>
<td>GA</td>
<td>Yes</td>
<td>46</td>
<td></td>
</tr>
<tr>
<td>Ray 2005 THA</td>
<td>10 g + 5 g over 3 h</td>
<td>Depending on patient’s condition</td>
<td>FPC + aspirin</td>
<td>Ultrasound</td>
<td>GA</td>
<td>Yes</td>
<td>30</td>
<td></td>
</tr>
</tbody>
</table>

First dose of α-aminocaproic acid (EACA) was started before surgery.

Double-blind: patients and investigators were blinded to treatment allocation; DVT = deep vein thrombosis; FPC = foot pump compression; GA = general anesthesia; Hb = hemoglobin; Ht = hematocrit; INR = international normalized ratio; IPC = intermittent pneumatic compression; LMWH = low-molecular-weight heparin; NA = data not available; RA = regional anesthesia; THA = total hip arthroplasty; UFH = unfractionated heparin.

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Fig. 1. Meta-analysis of use of antifibrinolytic compared with placebo or no treatment on the proportion of patients requiring allogeneic erythrocyte transfusion according to a transfusion protocol. The odds ratio for the individual studies is represented as a square within a bar representing the 95% confidence interval (CI). Symbol size is proportional to the study weight. The odds ratio for summaries is represented as a diamond. The width of the diamonds corresponds to the 95% CI. An odds ratio less than 1 indicates that the antifibrinolytic is more effective than placebo. If the value of 1 is included within the 95% CI, the result is not significant ($P > 0.05$).

**Tranexamic acid**

<table>
<thead>
<tr>
<th>Reference</th>
<th>Year</th>
<th>Surgery</th>
<th>Treated</th>
<th>Control</th>
<th>0.01</th>
<th>0.1</th>
<th>1</th>
<th>10</th>
<th>100 Odds Ratio [95% CI]</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hiippala S(53)</td>
<td>1995</td>
<td>TKA</td>
<td>10 / 15</td>
<td>13 / 14</td>
<td>0.15</td>
<td>0.02 to 1.53</td>
<td>0.08</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benoni G(54)</td>
<td>1996</td>
<td>TKA</td>
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<td>1997</td>
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<td>1999</td>
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<td>2 / 21</td>
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<td>47 / 73</td>
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<td>2003</td>
<td>TKA</td>
<td>3 / 27</td>
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<td>2004</td>
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<td>Johansson T(71)</td>
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<td>THA</td>
<td>12 / 59</td>
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<td>0.38</td>
<td>0.17 to 0.87</td>
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**Epsilon aminocaproic acid**

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<tr>
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<th>Surgery</th>
<th>Treated</th>
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<td>Harley B.J(72)</td>
<td>2002</td>
<td>THA</td>
<td>4 / 22</td>
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<td>Amar D(50)</td>
<td>2003</td>
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<td>12 / 22</td>
<td>14 / 24</td>
<td>0.86</td>
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<td>Murkin J.M(34)</td>
<td>1995</td>
<td>MOS</td>
<td>18 / 29</td>
<td>17 / 24</td>
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<td></td>
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<td>11 / 11</td>
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<td>12 / 37</td>
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<td>0.35 [0.11 to 1.12]</td>
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<td>19 / 228</td>
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<td>MOS</td>
<td>12 / 40</td>
<td>11 / 18</td>
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<th>Control</th>
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<td>3 / 10</td>
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<td>16 / 22</td>
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<td><strong>total</strong></td>
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<th>Reference</th>
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<th>0.01</th>
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<th>1</th>
<th>10</th>
<th>100 Odds Ratio [95% CI]</th>
<th>P</th>
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</table>
| Transfused blood before allogeneic blood when possible and according to a transfusion protocol. Data shown are allogeneic erythrocyte transfusion.

* Trials used autologous blood before allogeneic blood when possible and according to a transfusion protocol. Data shown are allogeneic erythrocyte transfusion.
Exploratory analyses did not find any influence of the type of anesthesia, the type of surgery, or the dose regimen for aprotinin. For example, the OR for aprotinin compared with placebo was 0.41 (0.22–0.74) in primary hip or knee arthroplasty and 0.44 (0.25–0.77) in major orthopedic surgery (heterogeneity test between subgroups; \( P = 0.85 \); fig. 3). Exploratory analyses did not suggest that the type of anesthesia modified the results for tranexamic acid. Trials with this latter drug were only performed in primary hip or knee arthroplasty. Although the results were not qualitatively influenced by the type of surgery, in quantitative terms, the results support a higher efficacy in knee arthroplasty for tranexamic acid compared with placebo (knee arthroplasty OR, 0.11 [0.06–0.18] vs. hip arthroplasty OR, 0.29 [0.17–0.52]; heterogeneity tests between subgroups \( P < 0.01 \); fig. 3). Furthermore, the efficacy of tranexamic acid in terms of requirement for transfusion of allogeneic erythrocytes seems to be modified by the regimen used. First, the efficacy \textit{versus} placebo was greater with a dose regimen of more than 30 mg/kg tranexamic acid (OR, 0.08 [0.04–0.17]) than with a lower dose regimen (OR, 0.21 [0.14–0.33]; fig. 3). The heterogeneity test between these two dose regimens is significant (\( P = 0.03 \)). Second, the results seem to favor the use of more than one single bolus dose of tranexamic acid (single bolus \textit{vs.} placebo: OR, 0.32 [0.17–0.63]; bolus followed by continuous infusion or repeated bolus \textit{vs.} placebo: OR, 0.12 [0.07–0.19]; heterogeneity tests between subgroups, \( P = 0.01 \); fig. 3).

The efficacy of aprotinin and tranexamic acid were also evaluated using a regression model. The linear regression revealed a significant correlation between the event rates (defined as the proportion of patients requiring allogeneic erythrocyte transfusion according to a transfusion protocol) in the active and control groups observed in the studies. This relation was evident not only for aprotinin (\( R^2 = 0.83 \), test of slope; \( P < 0.01 \)), but also for tranexamic acid (\( R^2 = 0.75 \), test of slope; \( P < 0.01 \); fig. 4).

**Other Efficacy Endpoints**

Aprotinin and tranexamic acid led to a significant decrease in the proportion of patients requiring any kind of erythrocyte transfusion (i.e., comprising allogeneic and/or preoperative autologous blood donation and/or cell salvage blood) according to a transfusion protocol (OR, 0.49 [0.33–0.73], \( P < 0.01 \) for aprotinin; 0.17 [0.12–0.25], \( P < 0.01 \) for tranexamic acid). The total perioperative blood loss was also significantly reduced with the use of aprotinin and tranexamic acid (standardized mean difference: 0.79 [0.64–0.94], \( P < 0.01 \) for aprotinin; 1.06 [0.68–1.43], \( P < 0.01 \) for tranexamic acid). EACA did not lead to a significant reduction in the total perioperative blood loss.

**Fig. 3.** Exploratory analyses of efficacy of aprotinin or tranexamic acid on allogeneic erythrocyte transfusion. The odds ratio for summaries is represented as a diamond. The width of the diamond corresponds to the 95% confidence interval (CI). An odds ratio less than 1 indicates that the antifibrinolytic is more effective than placebo. If the value of 1 is included within the 95% CI, the result is not significant (\( P > 0.05 \)).
The proportion of patients requiring any kind of erythrocyte transfusion (OR, 0.71 [0.29–1.73], \( P = 0.45 \)) or in total blood loss (standardized mean difference: 0.38 [−0.39 to 1.16], \( P = 0.33 \)) was 20.8% for aprotinin compared with placebo, 20.9% of venous thromboembolism was 8.6% earlier if clinically suspected, adjusted pooled incidence ing an objective test at the end of the study period or screened systematically for deep venous thrombosis us-
fibrinolytics. In double-blind randomized trials that
cant increase risk of venous thromboembolism for anti-
data.

Venous Thromboembolism
This meta-analysis did not show a statistically signifi-
cant increase risk of venous thromboembolism for anti-
fibrinolytics. In double-blind randomized trials that
screened systematically for deep venous thrombosis us-
ing an objective test at the end of the study period or
earlier if clinically suspected, adjusted pooled incidence
of venous thromboembolism was 8.6% versus 12% for
aprotinin compared with placebo, 20.8% versus 20.9%
for tranexamic acid compared with placebo, and 8.1%
versus 10.3% for EACA compared with placebo. The OR
was 0.67 (0.36–1.27; \( P = 0.22 \)) for aprotinin, 1.08
(0.49–2.39; \( P = 0.84 \)) for tranexamic acid, and 0.82
(0.18–3.67; \( P = 0.79 \)) for EACA (fig. 5). Similar estimates
of treatment effect for antifibrinolytics were achieved in
open-label studies and/or studies that only screened for
symptomatic venous thrombosis: Heterogeneity test be-
tween open and double-blind subgroups was \( P = 0.59 \)
for aprotinin, \( P = 0.61 \) for tranexamic acid, and \( P = 0.87 \)
for EACA (fig. 5). Therefore, all studies were pooled, and
the estimate of treatment effect did not reveal a statisti-
cally significant increase in venous thrombosis for each
antifibrinolytic compared with placebo (fig. 5).

Other Safety Endpoints
Analysis for other adverse events that may be related to
the use of antifibrinolytics was not performed because
these events were seldom reported. Seven hundred
twenty-three patients received aprotinin, and there was
1 case of non–ST-elevation myocardial infarction54 and 1
case of lower limb ischemia55; 1 patient died of septic
shock, rhabdomyolysis, and acute kidney failure67; and 2
had a nonfatal anaphylactic reaction.51,52 With tranex-
amic acid (575 patients), there was 1 case of myocardial
infarction.55 One patient with EACA (76 patients) re-
ported a rash postoperatively,74 and 3 reported a non-
ST-elevation myocardial infarction.54 Finally, in the pla-
ceso-treated patients (1,057 patients), 1 had a postoperative cerebrovascular accident,36 and another
had a myocardial infarction.47

Discussion
Meta-analysis is a retrospective examination that is
subject to the quality of the data of the included studies.
To minimize the possibility of bias, for an accurate esti-
mate of efficacy, we chose to perform a primary analysis
by including only double-blind randomized trials. Results
showed that the use of either aprotinin or tranexamic
acid in orthopedic surgery significantly reduced the pro-
portion of patients requiring erythrocyte transfusion ac-
cording to a transfusion protocol (as has been previously
shown in cardiac surgery or orthotopic liver transplan-
tation).7,73,74 With EACA, we did not find any significant
reduction of hemorrhagic risk, probably due to the small
number of trials included (2 trials with 101 participants).
Moreover, we performed an exhaustive review of the use
of antifibrinolytics in orthopedic surgery and to increase
the power of the analysis, we extended our selection to
open trials. To reduce bias we chose for our primary
outcome not to consider trials that did not use or did not
mention the use of a transfusion policy. Unfortunately,
because none of the trials included comment on the
extent to which the transfusion protocols were fol-
lowed, this could be a source of bias in open-label
studies. Therefore, we explored the robustness of our
findings through sensitivity analyses.75 Because these
analyses did not suggest that the open-label trials or any
individual trial exaggerated the magnitude of the esti-
mated treatment effect of aprotinin or tranexamic acid,
Fig. 5. Meta-analysis of use of antifibrinolytic compared with placebo or no treatment on venous thromboembolism. The odds ratio for the individual studies is represented as a square within a bar representing the 95% confidence interval (CI). Symbol size is proportional to the study weight. The odds ratio for summaries is represented as a diamond. The width of the diamonds corresponds to the 95% CI. An odds ratio greater than 1 indicates that the antifibrinolytic is at risk compared with placebo. If the value of 1 is included within the 95% CI, the result is not significant (P > 0.05). FUT = fibrinogen uptake test; VTE = venous thromboembolism.
open-label and double-blind studies were pooled. This permitted exploratory analyses for additional assessment of the use of antifibrinolytics in orthopedic surgery.

The regimen of antifibrinolytics used varied from one study to another. Because the optimal regimen in orthopedics had not previously been defined in randomized control studies, we explored the efficacy of aprotinin or tranexamic acid according to different covariables. With tranexamic acid, results showed a significant reduction of erythrocyte transfusion requirement whatever the regimen used. However, the effect was greater with the higher dosage. The OR was 0.21 (0.14–0.33) with a total dose lower than 30 mg/kg and 0.08 (0.04–0.17) with the higher dose. This may explain the discrepancy of results between knee and hip arthroplasty (fig. 3). In this latter surgical setting, which showed a lower efficacy than in knee arthroplasty, only the lower dose of tranexamic acid was used. With aprotinin, the exploratory analyses did not find any influence of any covariable analyzed; in particular, there was no significant dose–effect relation. It is noteworthy that the regimens of aprotinin used in orthopedic surgery were based on those used in cardiac surgery, with a primary preoperative loading dose followed, in most cases, by a continuous infusion limited to the intraoperative period. In orthopedic surgery, time taken for individual patients to achieve physiologic hemostasis in the postoperative period is uncertain. Besides, continual intraoperative bleeding may be responsible for partial washout of antifibrinolytics because reinfusion is not done immediately after blood loss, as in cardiac bypass surgery. This could explain the results observed with tranexamic acid that seem to favor administration of more than one single bolus limited to the intraoperative period (fig. 3). However, because the trials were not randomized with respect to the dose administered, the duration of treatment, and the timings of first administration, our evaluation of the different regimens of antifibrinolytics is evidently tentative and must be confirmed in further well-designed trials.

The efficacy of antifibrinolytics according to the underlying transfusion rate has not yet been investigated in clinical settings that are characterized by varying baseline risks of blood loss or transfusion.7 With this in mind, we performed a linear regression analysis. Results revealed a significant correlation between the transfusion rates in the antifibrinolytic and control groups (fig. 4). Although this linear regression is a post hoc analysis, it proposes an estimation of the efficacy of antifibrinolytics in different clinical settings and according to varying baseline risks of transfusion. Furthermore, this linear model is suggestive of a mixed-effects model, a combination of a multiplicative and additive model.9 Therefore, the number needed to treat for aprotinin or tranexamic acid to avoid transfusing one patient varies according to the different transfusion rates in the control group. For example, our linear regression suggests that with the use of tranexamic acid, the number needed to treat is five for a 20% transfusion rate in the control group and less than three for a 70% transfusion rate. We agree with Ho et al.76 that tranexamic acid is likely to be more useful in the clinical setting of a high transfusion rate: The higher the transfusion rate is, the lower the number needed to treat (multiplicative model) is. However, the magnitude of efficacy may not be as variable as they previously suggested (additive model).76

There are several issues that must be addressed. Summarized data on transfusion of fresh frozen plasma or platelets in the individual trials were insufficiently reported to perform a meta-analysis. Therefore, the reduction in transfusion observed in our review is limited to erythrocyte transfusion and is not predictive for other allogeneic blood elements. The included trials did not compare the efficacy and cost of antifibrinolytics to other effective interventions designed to minimize allogeneic erythrocyte transfusion, such as preoperative autologous blood donation, perioperative cell salvage, or the use of erythropoietin.77,78 Finally and more importantly, the safety of the use of antifibrinolytics remains a matter of concern. As previously suggested in cardiac surgery,7 our review did not demonstrate a statistically significant excessive risk of thromboembolic events with the use of antifibrinolytics. However, great care should be taken regarding the safety results. Trials selected for our analysis were designed to assess efficacy but were inadequate for the detection of adverse events. The small sample size of the trials was not sufficient to detect relatively infrequent, but clinically serious, safety events such as arterial thrombosis, renal failure, or rhabdomyolysis.6 Most studies lacked a prospective monitoring of safety outcomes, and due to enrollment criteria, patients at high risk of thromboembolic events, e.g., patients with a history of ischemic heart disease, were often excluded. As a consequence, the reported rate of adverse events is underestimated in our review. For example, there were only 2 cases of myocardial infarction among 2,431 patients (0.08% [95% confidence interval, 0–0.2%]), a lower frequency than previously reported in orthopedic arthroplasty surgery (0.4%).79 Besides, it seems that the different antifibrinolytics may not have the same frequency of serious adverse events.80 The evaluation of venous thromboembolic events was less limited because several double-blind randomized trials prospectively and systematically assessed this endpoint with an objective test. Furthermore, the observed incidence of venous thrombosis was much higher than arterial thrombosis, allowing a more precise estimation (fig. 5). The lack of any significant excessive risk of venous thromboembolism with the use of antifibrinolytics could be due to the systematic use of venous thrombosis prophylaxis in these studies. Nevertheless, due to the wide confidence intervals of the summary estimate for venous thromboembolic events, this review cannot determine whether
the administration of these agents increases the incidence of severe and venous thrombosis. Therefore, no definite conclusions regarding venous thromboembolic events can be drawn from this review. Finally, there are concerns about the safety of aprotinin because it is a polypeptide derived from bovine lungs and possesses antigenic properties.6 Among the 723 patients who received aprotinin in our analysis, 2 had a nonfatal anaphylactic reaction.

In conclusion, this analysis suggests that the use of aprotinin and tranexamic acid in orthopedic surgery significantly reduces the risk of allogeneic erythrocyte transfusion. However, results were too scarce for the evaluation of safety. Therefore, no definite conclusions regarding the clinical benefit-risk ratio of the use of antifibrinolytics in orthopedic surgery can be derived from our review. Larger prospective trials are required to define the optimal regimen, to assess the safety and cost-effectiveness of antifibrinolytics before recommending their use in orthopedic surgery.

References

29. Uttal J, Mrozik M, Scondon Henrik P. Use of high-dose aprotinin during spinal surgery results in a reduction in both blood loss and the amount of blood transfused. Br J Anaesth 1998; 80 (suppl 1):80


64. Mantilla CB, Horlocker TT, Schroder DR, Berry DJ, Brown DL. Frequency of myocardial infarction, pulmonary embolism, deep venous thrombosis, and death following primary hip or knee arthroplasty. *Anesthesiology* 2002; 96:1140–6


