Plasma anti-FXa level as a surrogate marker of the adequacy of thromboprophylaxis in critically ill patients: A systematic review

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1. Introduction

Critically ill patients are at increased risk of venous thromboembolism (VTE) because of several additive risk factors [1,2], with the critical illness itself acting as a hypercoagulable state [3,4]. In addition, withholding anticoagulant prophylaxis because of an elevated bleeding risk may predispose to VTE [5]. Therefore, the incidence of deep vein thrombosis (DVT) varies widely, from 10% to almost 100% [2,6]. Hospital mortality rates in patients with VTE have been reported to be relatively high, up to 28% [7]. In addition, VTE has been associated with increased risks of longer durations of mechanical ventilation and hospitalization [1].

Current guidelines of the American College of Chest Physicians (ACCP) recommend the use of low-molecular-weight heparin (LMWH) or unfractionated heparin (UFH) to prevent VTE in critically ill patients [8]. However, data supporting the thromboprophylactic effects of LMWH and UFH are mainly based on studies in medical and surgical ward patients, in which LMWHs were superior to UFH in preventing VTE [9]. LMWHs have also become the drug of choice for patients in the intensive care unit (ICU) owing to their more predictable and reproducible dose responses without the need for monitoring [10]. Furthermore, LMWHs have a lower risk of heparin-induced thrombocytopenia than UFH [11]. However, despite the almost routine use of pharmacological prophylaxis, the incidence of VTE has remained relatively high, between 5% and 16% [11,12], raising questions about the adequacy of current recommendations in heterogeneous high-risk groups of ICU patients.

The antithrombotic effects of LMWHs are mainly owing to their enhancement of the inhibitory effects of the intrinsic anticoagulant anti-thrombin III (AT III) on activated factor X (FXa) and thrombin (FIIa). Each LMWH has its own pharmacological profile (i.e., molecular weight distribution and anti-FXa/anti-FIIa activities), which must be considered when interpreting laboratory results [13]. As all LMWHs are predominantly cleared by the kidneys, patients with renal insufficiency may be predisposed to bleeding. Therefore, monitoring the pharmacological effects of LMWHs by measuring anti-FXa levels has been recommended only in patients with renal insufficiency or with other special circumstances (e.g., morbid obesity) [10]. To date, recommendations for adequate anti-FXa levels in critically ill patients have not been proposed, nor is it known whether the peak or trough level should be measured. Peak levels are generally regarded as reflecting thromboprophylactic effect, whereas trough levels are regarded as reflecting accumulation. However, it is unclear whether high peak levels predispose to bleeding.
or low trough levels to thrombosis. This systematic review was
designed to determine anti-FXa levels in blood of critically ill patients
after prescribed LMWH thromboprophylaxis and to evaluate whether
clinically relevant events (e.g., VTE or bleeding) correlate with anti-
FXa levels.

2. Methods

This systematic review is based on the methodology recommended by
the Cochrane Collaboration. PRISMA Statement and Moose reporting rec-
ommendations were used. The protocol was published on the PROSPERO
register (www.crd.york.ac.uk/PROSPERO, number CRD42015025744) before final data extraction.

2.1. Data sources and search strategy

MEDLINE, SCOPUS, the Cochrane Library, and the ClinicalTrials.com
databases were searched in collaboration with a librarian from the Univer-
sity of Helsinki, using the terms Venous Thrombosis/thromboprophylaxis/
Venous Thromboembolism AND Critical Care/Intensive Care Unit/Critical
Illness AND LMWH. There were no restrictions on language, date, or type
of publication. The initial search was completed in May 2015. The refer-
ence lists of all retrieved articles were manually reviewed to identify any
potentially relevant studies. Details of the search strategies are shown in
Supplement 1.

2.2. Study selection

Predefined inclusion criteria were used. Studies had to be prospec-
tive in design, performed in adult (age >18 years) critical care patients,
include more than 10 patients, use any LMWH thromboprophylaxis,
and include at least one anti-FXa measurement at a known time point
after specified LMWH administration. All abstracts and titles were
screened independently by two reviewers (AV and AK). The full text
of every identified article was read. Agreement between the two
reviewers on article inclusion was high (kappa value 0.89), with any
disagreements resolved through discussions.

2.3. Data extraction and quality assessment

The selected studies were independently reviewed by the same two
investigators (AV and AK), and data were extracted using predefined
criteria, including the study design, patient population, anti-FXa results,
and clinical outcomes (i.e., DVT, symptomatic DVT, pulmonary embo-
lism (PE), symptomatic PE, and major or minor bleeding based on the
original trial definition). The quality of eligible studies was assessed
using the Downs and Black checklist [14], and any disagreement was re-
solved by consensus. Quality assessment is presented as total Downs
and Black score (maximum, total score 27), as well as by subgroup
scores (reporting, external validity, internal validity-bias, internal
validity-confounding). Because of the high heterogeneity of clinical
outcomes in included studies, quantitative analyses could not be
performed.

3. Results

The initial search identified 5206 citations, after duplicates were re-
moved. Of these, 31 studies were retrieved for more detailed evaluation
and 18 studies, including 1644 patients, were included in the final
systematic review (Fig. 1). These studies were mainly observational,
with only two randomized clinical trials (RCTs) identified. Trial charac-
teristics are presented in Table 1. Most of these studies (10 observa-
tional studies and two RCTs) tested the effects of different dosages of
enoxaparin [15–26], whereas four observational studies assessed
dalteparin [27–30], and one each tested certoparin [31] and nadroparin
[32]. No studies testing tinzaparin were identified. The median peak
anti-FXa levels in ICU patients varied widely, from <0.1 IU/mL [31] to
0.35 IU/mL [27]. The median trough anti-FXa levels were reported in
four studies, and they varied between undetectable and <0.1 IU/mL
[27,31,18,20].

The quality of the studies according to the Down and Black score is
shown in Table 2. The median total score (interquartile range, IQR)
was 19 [15–20]/27. The median subscores (IQR) were 8.5 [7–10]/11
for reporting, 1 [1–2]/3 for external validity, 5 [4–5]/7 for internal
validity-bias, and 3 [2–5]/7 for internal validity-confounding and power.
3.1. Certoparin

The only observational study of certoparin included 62 critically ill patients. Treatment with 3000 IU OD certoparin resulted in a median peak anti-FXa level that was undetectable (<0.1 [IQR 0.1–0.2]) IU/mL. Only 28% of patients were within the antithrombotic range using the study definition of target value. When the dosage was doubled to 3000 IU bid, the median peak anti-FXa level did not change but 47% of patients were within the recommended range. Median trough levels in patients administered 3000 IU OD and bid certoparin were undetectable (<0.1 [IQR 0.1–0.17]) and <0.1 [IQR 0.1–0.26] IU/mL, respectively. One patient in the lower dose group experienced severe PE, but the anti-FXa concentration of this patient was not reported. There was no correlation between bleeding and high anti-FXa levels (>0.3 IU/mL) [31].

3.2. Dalteparin

Four studies were identified. The first study, involving patients in the ICU with renal insufficiency (creatinine clearance “CrCl” < 30 mL/min) administered 5000 IU OD dalteparin, reported median peak anti-FXa levels 4 h (hrs) after treatment to be 0.29 (IQR 0.20–0.42) IU/mL after 3 days and 0.34 (IQR 0.27–0.45) IU/mL after 17 days. Trough levels were undetectable. The incidence of major bleeding was 7.2% and two patients died of bleeding complications. However, there was no correlation between anti-FXa levels and deaths [27]. Similar results were observed in a small observational study of patients with renal insufficiency (“CrCl” < 30 mL/min) [29].

The third study was a before and after study, in which dalteparin dosage was doubled if the anti-FXa level at 12 h was below <0.1 IU/mL. The protocol reduced the total incidence of VTE (12.8% vs. 7.0%, p = 0.009). Moreover, if the median anti-FXa level was below <0.1 IU/mL at 12 h, the rates of VTE (14.4% vs. 5.4%, p = 0.05) and DVT (14.4% vs. 3.2% vs. 0.01) were significantly higher [28].

In the fourth study, the pharmacokinetics of dalteparin were assessed in edematous and non-edematous ICU patients. There were no between-group differences in mean ± standard deviation (SD) peak (0.15 ± 0.05 vs. 0.14 ± 0.06 IU/mL) and trough (0.05 ± 0.06 vs. 0.02 ± 0.02 IU/mL) anti-FXa concentrations [30].

3.3. Enoxaparin

Median peak anti-FXa levels tended to be lower in ICU than in medical ward patients: 0.16 (IQR 0.0–0.22) vs 0.2 (IQR 0.15–0.27) IU/mL [16]. Similar results were observed when the area under curve (AUC)0–12 h was measured (SD 2.63 ± 1 vs. 4.26 ± 1.7 IU/mL/h) [21]. Two RCTs also showed positive correlations between enoxaparin dosage and median peak and mean anti-FXa levels [22,23]. Five studies reported trough levels, which were generally low (0–0.10 IU/mL) and in one study the low trough level correlated with the incidence of DVT (37 vs. 11%, p = 0.026) [19]. Median trough levels were generally low or undetectable [18,20]. Nine studies reported adverse events, with none of these studies detecting any correlation between bleeding events and anti-FXa levels [15,18–20,22,23,24,33,26].

3.4. Nadroparin

Only one observational study was found, in which nadroparin 2850 IU OD was compared in three different patient groups: ICU patients on vasopressors (n = 15), ICU patients not on vasopressors (n = 15), and surgical ward patients (n = 15). The mean peak anti-FXa levels at 3 h were 0.09 (95% confidence interval [CI] 0.05–0.10), 0.23 (95% CI 0.18–0.27), and 0.28 (95% CI 0.23–0.31) IU/mL respectively. Trough levels were not measured, and clinical outcomes were not reported [32].

4. Discussion

This systematic review, which included 16 observational studies and two RCTs, found a lack of evidence regarding optimal targeted anti-FXa levels in critically ill patients. Median peak anti-FXa levels (<0.1–0.35 IU/mL) [31,27] and mean anti-FXa levels (0.09–0.40 IU/mL) [32,23] varied widely, depending on the type and dose of LMWH and on the study population. In addition, the trough levels were consistently low [27,31,18,20,29,30,24,33]. Data on peak and trough anti-FXa levels after LMWH thromboprophylaxis in ICU patients are sparse, and more research is certainly needed. Irrespective of LMWH drug and dose, peak and trough anti-FXa levels were generally low throughout the studies, but correlations between anti-FXa levels and clinically relevant outcomes, such as DVT, PE, and bleeding, remain uncertain. However, one study found that a low trough anti-FXa level significantly increased the incidence of DVT (37% vs. 11%, p = 0.026) [19].

These findings may have several explanations. First, AT III levels in critically ill patients were consistently low, correlating with low anti-FXa levels [31,21]. Low AT III levels may be due to elevated levels of other heparin-binding proteins (e.g., fibronectin and vitronectin), as observed in an animal endotoxin model [34]. Second, the absorption of subcutaneously administered LMWH may be reduced in patients treated with a vasopressor, reducing systemic bioavailability [32]. Third, critically ill patients often receive excessive amounts of intravenous fluids, resulting in peripheral edema, which may affect LMWH pharmacokinetics and reduce its bioavailability [17].

Administration of a standard prophylactic dosage of LMWH to obese ICU patients resulted in lower anti-FXa activity than in non-obese individuals [28,20]. However, enoxaparin dose may be positively correlated with anti-FXa levels, with adequate peak anti-FXa levels achieved using a weight-adjusted dose of enoxaparin (1 mg/kg once daily) [23].

Because of the lack of good quality RCTs [35], evidence of the effectiveness of LMWH thromboprophylaxis in ICU patients is mainly based on measurements of plasma levels of anti-FXa, as anti-FXa is a surrogate marker for anticoagulant effects. Correct anti-FXa levels have been determined only in patients undergoing orthopedic surgery [36,9]. It has not yet been determined whether peak or trough level should be measured. The generally recommended peak anti-FXa level for thromboprophylaxis is 0.1–0.3 IU/mL in medical and surgical patients [37]. The rates of VTE in patients undergoing hip surgery with trough (12 h after administration of enoxaparin) anti-FXa activity of >0.1 IU/mL, <0.1 IU/mL, and <0.05 IU/mL were reported to be 6.3%, 14.6%, and 18.8%, respectively. Anti-FXa levels >0.2 IU/mL were associated with hematomas [36]. These values are also generally used as references for anticoagulant effects in ICU patients in the observational studies included in this review.

Two of the observational studies were conducted in critically ill patients with renal insufficiency. Administration of a prophylactic dose of dalteparin to patients with impaired renal function (“CrCl” < 30 mL/min) did not alter median peak anti-FXa levels [29,27] nor was there evidence of an increased risk of bleeding, despite a mean ± SD CrCl of 18.9 ± 6.5 mL/min [27]. Lower serum creatinine and urea levels (not specified) were associated with a greater clearance of LMWH (certoparin), as measured by lower plasma anti-FXa levels [31].

Renal insufficiency is one of the most frequent reasons for omission of pharmacological thromboprophylaxis or for preferring UFH over LMWH [5]. Current research evidence does not support this practice, but these data are observational and limited. Moreover, urinary CrCl is an imprecise estimate of glomerular filtration rate in critically ill patients [38]. A meta-analysis that included patients with severe renal insufficiency (“CrCl” < 30 mL/min) found that only when therapeutic doses of enoxaparin were administered were anti-FXa levels elevated and the risk of major bleeding increased [39]. Prophylactic administration of enoxaparin but not of tinzaparin showed similar accumulation findings in elderly medical patients with impaired renal function (“CrCl” 34 ± 11.4 mL/min) [40].
<table>
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<tr>
<th>Study Population</th>
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<th>Peak anti-FXa levels IU/ml</th>
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<tr>
<td>Certoparin</td>
<td>Mixed ICU</td>
<td>Single-center, prospective, open label study (n = 30 + 32)</td>
<td>Certoparin 3000 IU s.c. OD and 3000 IU s.c. bid</td>
<td>At 0, 4, 12 and 24 h</td>
<td>Median (IQR) at 4 h &lt; 0.1 (&lt;0.1–0.2) vs. &lt;0.1 (&lt;0.1–0.28)</td>
<td>Median (IQR) &lt; 0.1 (&lt;0.1–0.17) vs. &lt;0.1 (&lt;0.1–0.26)</td>
<td>One PE in certoparin 3000 IU OD group</td>
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<tr>
<td>Dalteparin</td>
<td>ICU patients with renal insufficiency (CrCl &lt; 30 ml/min)</td>
<td>Multi-center, single-arm, open label study (n = 138/156)</td>
<td>Dalteparin 5000 IU s.c. OD</td>
<td>At 0, 1, 2, 4, 8, 12, 20 and 24 h and on days 3, 10 and 17</td>
<td>Median (IQR) at 4 h; after 3 days 0.29 (0.20–0.42), 10 days 0.35 (0.24–0.43), 17 days 0.34 (0.27–0.45)</td>
<td>Median (IQR) &lt; 0.10 (&lt;0.10–0.10) (n = 120)</td>
<td>5.1% DVT, 7.2% major bleeding, 1.4% HIT. Two patients died with bleeding.</td>
</tr>
<tr>
<td>[28] TICU</td>
<td>Single-center, before and after, prospective study (n = 190/785)</td>
<td>Dalteparin 5000 IU s.c. OD</td>
<td>Before: dalteparin 5000 IU s.c. OD, after: dalteparin 5000 IU s.c. OD if anti-Xa &lt; 0.1 IU/ml</td>
<td>At 12 h</td>
<td>Not measured</td>
<td>Not measured</td>
<td>Pre vs. post protocol: overall VTE 12.8% vs. 7.0% (p = 0.009)</td>
</tr>
<tr>
<td>[29] Mixed ICU patients with renal insufficiency (CrCl &lt; 30 ml/min)</td>
<td>Single-center, prospective, cohort study (n = 19)</td>
<td>Dalteparin 5000 IU s.c. OD</td>
<td>Dalteparin 5000 IU s.c. OD</td>
<td>At 4 h and 22–23 h</td>
<td>Mean (95% CI) at 4 h 0.30 (0.27–0.33)</td>
<td>Only 3/19 patients had levels above detection threshold (&lt;0.1)</td>
<td>One catheter-related thrombus, two macroscopic bleeding</td>
</tr>
<tr>
<td>[30] Mixed ICU</td>
<td>Two-center open label study, edematous (n = 7) vs. nonedematous (n = 7)</td>
<td>Dalteparin 2500 IU s.c. OD</td>
<td>Dalteparin 2500 IU s.c. OD</td>
<td>At 0, 3, 4, 6, 8, 12 and 24 h</td>
<td>Mean (SD) at 3 h: 0.15 (0.05) vs. 0.14 (0.06)</td>
<td>Mean (SD) 0.05 (0.06) vs. 0.02 (0.02)</td>
<td>Not reported</td>
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<tr>
<td>Enoxaparin</td>
<td>SICU (trauma ISS 24 ± 10.9)</td>
<td>Single-center, prospective, open label study (n = 61). LMWH dosing was increased if peak anti-FXa was &lt;0.2 IU/ml</td>
<td>Enoxaparin 30 mg s.c. bid (initial dose) up to 60 mg s.c. bid</td>
<td>At 4 h on the 3rd dose and before the 4th dose</td>
<td>At 4 h sub-therapeutic (&lt;0.2) in 70.5% (n = 43)</td>
<td>Not reported</td>
<td>4.9% VTE, did not correlate to anti-FXa levels. No bleeding events.</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Study Population</th>
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<tr>
<td>MICU vs. general medical ward</td>
<td>Single-center, prospective, controlled open label study (n = 15 + 16)</td>
<td>Enoxaparin 40 mg s.c. OD</td>
<td>At 0, 1, 3, 6 and 12 h</td>
<td>Median (IQR) 3 h 0.16 (0.02–0.22) vs. 0.2 (0.15–0.27)</td>
<td>Not measured</td>
<td>Not reported</td>
<td>Rotachrom HBPM/LMWH©</td>
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<td>TICU (ISS &gt;10)</td>
<td>Single-center, prospective cohort study, nonedematous (n = 11/14) vs. edematous (n = 10/11)</td>
<td>Enoxaparin 30 mg s.c. bid</td>
<td>At 0, 1, 3, 4, 6, 8 and 12 h</td>
<td>Median (IQR) 3 h 0.27 vs. 0.12</td>
<td>IQR not reported</td>
<td>Not reported</td>
<td>Not reported</td>
</tr>
<tr>
<td>MICU</td>
<td>Single-center, prospective, observational study (n = 55)</td>
<td>Enoxaparin 40 mg s.c. OD</td>
<td>At 0, 1, 2, 3, 4, 5 and 6 h before the 4th dose</td>
<td>Median (IQR) 3 h 0.27 vs. 0.12</td>
<td>IQR not reported</td>
<td>Not reported</td>
<td>Chorm Z Heparin Kit©</td>
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<td>SICU</td>
<td>Single-center, prospective, observational study (n = 54)</td>
<td>Enoxaparin 30 mg s.c. bid</td>
<td>At 0, 1, 2, 3, 4, 6, 8 and 12 h</td>
<td>Median (IQR) 4 h 0.18 (0.06–0.52) vs. 0.08 (0.02–0.15)</td>
<td>IQR not reported</td>
<td>Not measured</td>
<td>STA-STALECT Heparin©</td>
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<tr>
<td>Mixed ICU</td>
<td>Single-center, prospective, observational study (n = 89)</td>
<td>Enoxaparin 40 mg s.c. OD</td>
<td>At 0, 1, 2, 3, 4, 6, 8 and 12 h</td>
<td>Median (IQR) 4 h 0.22 (0.17–0.37) vs. 0.18 (0.12–0.27)</td>
<td>IQR not reported</td>
<td>Not measured</td>
<td>Coamatic Heparin©</td>
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<tr>
<td>Mixed ICU vs. medical ward patients</td>
<td>Single-center, prospective, controlled open label study (n = 16 + 13)</td>
<td>Enoxaparin 40 mg s.c. OD</td>
<td>At 0, 1, 2, 3, 4, 5 and 6 h before the 4th dose</td>
<td>Median (IQR) 4 h 0.18 (0.12–0.30) vs. 0.27 (0.15–0.29)</td>
<td>IQR not reported</td>
<td>Not measured</td>
<td>Coamatic Heparin©</td>
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<tr>
<td>Mixed ICU</td>
<td>Single-center, prospective, randomized double blind study (n = 18 + 16 + 20 + 18)</td>
<td>Enoxaparin 40, 50, 60 or 70 mg s.c. OD</td>
<td>At 0, 1, 2, 3, 4, 5, 6, 7, 8 and 9 h before the 4th dose</td>
<td>Median (IQR) 4 h 0.13, 0.14, 0.27 vs. 0.29</td>
<td>IQR not reported</td>
<td>No thromboembolic complications</td>
<td>Coamatic Heparin©</td>
</tr>
<tr>
<td>Mixed ICU</td>
<td>Single-center, prospective, randomized double blind study (n = 20 + 20 + 19 + 19)</td>
<td>Enoxaparin 40 mg s.c. OD, 30 mg s.c. bid or 40 mg s.c. bid or 1 mg/kg s.c. OD</td>
<td>At 0, 1, 2, 3, 4, 5, 6, 7, 8 and 9 h before the 4th dose</td>
<td>Mean (SD) 4 h on the 1st day: 0.20, 0.08, 0.17, 0.34 on the 3rd day: 0.13, 0.14, 0.33, 0.40</td>
<td>SD not reported</td>
<td>No adverse events</td>
<td>Coamatic Heparin©</td>
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<tr>
<td>TICU (ISS &gt;10)</td>
<td>Single-center, prospective, open label, cohort study (n = 17)</td>
<td>Enoxaparin 40 mg s.c. OD</td>
<td>At 0, 1, 2, 3, 4, 5, 6, 7, 8 and 9 h before the 4th dose</td>
<td>Median (IQR) 4 h 0.13, 0.14, 0.27 vs. 0.29</td>
<td>IQR not reported</td>
<td>One minor nosebleed</td>
<td>Coamatic Heparin©</td>
</tr>
<tr>
<td>Mixed ICU</td>
<td>Single-center, prospective, open label study (n = 36)</td>
<td>Enoxaparin 30 mg s.c. bid</td>
<td>At 0, 1, 2, 3, 4, 5, 6, 7, 8 and 9 h before the 4th dose</td>
<td>Mean (SD) 4 h on the 1st day: 0.20, 0.08, 0.17, 0.34 on the 3rd day: 0.13, 0.14, 0.33, 0.40</td>
<td>SD not reported</td>
<td>One DVT, no bleeding</td>
<td>Stago Rotachrom Heparin kit©</td>
</tr>
<tr>
<td>MICU sepsis patients</td>
<td>Single-center, prospective, open label study (n = 16)</td>
<td>Enoxaparin 40 mg s.c. OD</td>
<td>At 0, 1, 2, 3, 4, 5, 6, 7, 8 and 9 h before the 4th dose</td>
<td>Median (IQR) 4 h 0.13, 0.14, 0.27 vs. 0.29</td>
<td>IQR not reported</td>
<td>One DVT, one bleeding, one thrombocytopenia</td>
<td>Coamatic Heparin©</td>
</tr>
<tr>
<td>Nadroparin</td>
<td>Single-center, ICU patients on vasopressors (n = 15) vs. ICU patients not on vasopressors (n = 15) vs. surgical ward patients (n = 15)</td>
<td>Nadroparin 2850 IU s.c. OD</td>
<td>At 0, 1, 2, 3, 4, 5, 6, 7, 8 and 9 h</td>
<td>Mean (SD) 4 h at 0.19 (0.09) vs. 0.18 (0.09)</td>
<td>Not measured</td>
<td>One DVT, one bleeding, one thrombocytopenia</td>
<td>Coamatic Heparin©</td>
</tr>
</tbody>
</table>

Abbreviations
ICU, indicates intensive care unit; CrCl, creatinine clearance; TICU, trauma intensive care unit; SICU, surgical intensive care unit; MICU, medical intensive care unit; ISS, injury severity score; LMWH, low-molecular weight heparin; s.c., subcutaneous; OD, once daily; bid, twice daily; hrs, hours; h, hour; IQR, interquartile range; CI, confidence interval; SD, standard deviation; AUC, area under curve; PE, pulmonary embolism; DVT, deep venous thrombosis; HIT, heparin induced thrombocytopenia; VTE, venous thromboembolism.
The critical illness itself often acts as a hypercoagulable state (e.g., sepsis or trauma) [3]. In addition, the severity of critical illness (e.g., multiple organ dysfunction score or severity of burn injury) was reported to correlate with lower anti-FXa [41,20]. Whether the latter reflects an insufficient anticoagulant effect or the nature of anti-FXa as a surrogate marker requires further investigations.

These findings of low levels of anti-FX activity and several conditions that can alter LMWH bioavailability in intensive care patients have raised the question of the adequacy of thromboprophylaxis with dosing schemes applied to medical and surgical patients. Although VTE events have decreased with LMWH prophylaxis, thromboembolism has occurred, despite recommended dosing of LMWHs and even within recommended anti-FXa levels [19]. In addition to the reasons described above, uneventful thrombosis may result from a fear of bleeding, resulting in pauses and delays in thromboprophylaxis [5].

### 4.1. Strengths and limitations

To our knowledge, this is the first systematic review of the role of anti-FXa monitoring during LMWH thromboprophylaxis in critically ill patients. However, this study had several limitations. First, all included studies were relatively small, with most being observational and underpowered for clinical endpoints, and of low quality. Second, as the type of ICUs varied among studies (i.e., mixed, medical, trauma, and surgical) and patients had various degrees of renal failure, the study population was quite heterogeneous. The benefits and adverse effects of LMWH may vary in different subgroups of ICU patients. Third, the type and dose of LMWH varied among studies; because LMWHs have different pharmacological properties, it is unclear whether anti-FXa levels can be generalized. Fourth, there were methodological limitations concerning anti-FXa measurements, as the protocols of the included studies were not identical (e.g., times samples were obtained after LMWH administration, blood sample collecting procedures, and delay from sampling to analysis) and the analytic methods and reference levels differ among laboratories. Moreover, the reporting of measured anti-Xa activity concentrations in the studies varied (e.g., median, mean or AUC), making data interpretation difficult. Fifth, the secondary outcomes should also be considered a study limitation because the definitions of these adverse events (e.g., DVT, symptomatic DVT, PE, symptomatic PE, and minor or major bleeding) varied across studies. Sixth, the literature search was updated in May 2015; thus, more recent data may be missing.

### 5. Conclusion

No definite conclusions can be drawn regarding target anti-FXa levels in critically ill patients administered LMWHs for thromboprophylaxis. No recommendations can be made on the timing of anti-FXa monitoring or for dose adjustments for individual patients.

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AV, SV, VP and AK planned and designed the study. AV and AK acquired and reviewed the data and assessed risk of bias. All authors revisied the manuscript critically with a contribution and gave final approval of the version to be published. No external funding was received.

### Appendix A. Supplementary data

Supplementary data to this article can be found online at http://dx.doi.org/10.1016/j.thromres.2015.12.016.

### References


### Table 2

Down and Black checklist.

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IQR indicates interquartile range.


