How do type of preoperative P2Y$_{12}$ receptor inhibitor and withdrawal time affect bleeding? Protocol of a systematic review and individual patient data meta-analysis

Michael Schoerghuber,1 Gudrun Pregartner,2 Andrea Berghold,2,3 Robert Zweiker,4 Andreas Voetsch,5 Elisabeth Mahla,1 Andreas Zirlik4

ABSTRACT

Introduction In order to reduce the risk of bleeding in patients on P2Y$_{12}$ receptor inhibitors presenting for non-emergent coronary artery bypass grafting (CABG), current guidelines recommend a preoperative discontinuation period of at least three, five and seven days for ticagrelor, clopidogrel and prasugrel, respectively, to allow for recovery of platelet function. However, there is still substantial interinstitutional variation in preoperative management and relevant covariates of CABG-related bleeding are largely elusive so far.

Methods and analysis We will search PubMed (July 2013 to November 2021) and EMBASE (January 2014 to November 2021) using the following terms, MeSH terms and their synonyms: clopidogrel, prasugrel, ticagrelor, dual antiplatelet, P2Y$_{12}$ receptor inhibitor, CABG, bleeding, haemorrhage. Two independent reviewers will screen all abstracts and full papers for eligibility. Disagreements will be solved by consulting with a third reviewer. The primary outcome is the incidence of Bleeding Academic Research Consortium (BARC) 4 bleeding depending on type of P2Y$_{12}$ receptor inhibitor and preoperative withdrawal period. The secondary outcomes are mortality and ischaemic events according to the Academic Research Consortium 2 Consensus Document. We will perform an individual patient data meta-analysis (IPD-MA) with drug-specific preoperative withdrawal time and adjust for demographic and procedural variables. Subgroup analyses will be performed for anaemic patients and patients undergoing non-emergent versus urgent/emergent surgery.

Ethics and dissemination This IPD-MA consists of secondary analyses of existing non-identifiable data and meets the criteria for waiver of ethics review by the local Research Ethics Committee. Data sharing and transfer will be subject to a confidentiality agreement and a data use agreement. Findings will be disseminated through peer-reviewed publication and conference presentation.

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BACKGROUND

In the 54 European Society of Cardiology (ESC) member countries, 34.9 million people lived with ischaemic heart disease in 2017. The median age-standardised prevalence per 1 000 000 inhabitants of each member country was 2270 (IQR 1508–2565) and was lower for females compared with males. In the 2018/2019 survey, these figures translated into a median of 2047 (IQR 1478–2588) percutaneous coronary interventions and
301.1 (IQR 245.0–440.0) coronary artery bypass grafting operations (CABGs) per one million inhabitants.7 Dual antiplatelet therapy (DAPT) with a P2Y12 receptor inhibitor on top of aspirin is the cornerstone to prevent thrombotic complications in patients with acute coronary syndromes (ACS) and/or after percutaneous coronary interventions with stents, although at the risk of increased bleeding.2 5

Large observational studies have demonstrated an association between the severity of cardiac surgery-related bleeding and 30-day postoperative morbidity and mortality.6 10 A sub-study of the Transfusion Avoidance in Cardiac Surgery study demonstrated that two consensus-based scoring systems for assessing the severity of bleeding, the Universal Definition of Perioperative Bleeding in Adult Cardiac Surgery (UDP) and the European Coronary Artery Bypass Grafting Bleeding Severity Grade instead of European Coronary Artery Bypass Graft (E-CABG), performed well in predicting 28-day mortality. Specifically, severe bleeding defined as either UDPB class 3 or E-CABG grade 2, both of which comprise transfusion of ≥5 units of red blood cells, was associated with about 40% relative increased risk of mortality.6 Suggested mechanisms for bleeding-associated mortality are organ dysfunctions triggered by decreased oxygen delivery and hypotension following major blood loss in patients with atherosclerotic disease and adverse effects of transfusion.11 12 Preventing perioperative blood loss may be more efficacious in improving outcome than mere reduction of allogenic blood components.7

Currently, almost 11% of patients presenting with ACS have to undergo aorto-coronary bypass grafting during DAPT.15

In order to reduce the risk of bleeding in patients on P2Y12 receptor inhibitors presenting for non-emergent cardiac surgery, current ESC and American Heart Association/American College of Cardiology (AHA/ACC) guidelines recommend a ‘standardised’ preoperative discontinuation period of at least 3 days for ticagrelor, 5 days for clopidogrel and 7 days for prasugrel (IIa recommendation) to allow for recovery of platelet function.14 15 However, there is still substantial inter-institutional variation in preoperative management of ACS patients on DAPT, and there is heterogeneity in the definition and incidence of bleeding. Moreover, data on prasugrel are sparse.7 16

Two big registries used different bleeding definitions to evaluate the overall incidence of major CABG-related bleeding in patients on clopidogrel as compared with ticagrelor and the specific impact of preoperative withdrawal time.8 9 The Swedish registry including 2244 patients with ACS who underwent CABG demonstrated a 5% lower incidence of Bleeding Academic Research Consortium (BARC) type-4 bleeding in patients on ticagrelor as compared with clopidogrel (12.9% vs 17.6%, p=0.033). This difference was mainly driven by a sharp decline in bleeding after 72 hours withdrawal of ticagrelor as compared with a more gradual decrease with clopidogrel. Importantly, incidence of BARC-4 bleeding was 38% and 31% when ticagrelor / clopidogrel was discontinued less than 24 hours, preoperatively.8 In contrast, a subgroup analysis of 1376 patients from the E-CABG registry demonstrated a similar incidence of severe or massive UDPB (11.2% vs 8.7%, p=0.14) and BARC-4 bleeding (13.2% vs 11.6%, p=0.38) in clopidogrel and ticagrelor treated patients, and a similar decrease in bleeding with increasing days off P2Y12 receptor inhibitors, compatible with time-dependent recovery of platelet function. In a propensity score-matched analysis, 4–5 days off clopidogrel reduced severe/massive UDPB class by 7.3% as compared with a 3-day preoperative withdrawal period (p=0.031). Similarly, 3 days off ticagrelor reduced bleeding by 13.3% as compared with a 0–2 days preoperative withdrawal period (p=0.003).9

However, the additional impact of covariates known to affect CABG-related bleeding, the potential bias introduced by preoperative anaemia, occurring in up to 40% of patients undergoing cardiac surgery, and the incidence of myocardial infarction in this particular patient population remain largely elusive so far.17–21

The proposed review is therefore needed to determine the effect of preoperative P2Y12 receptor inhibitors and time of preoperative withdrawal in patients undergoing on-pump CABG on primary (BARC-4 bleeding) and secondary outcomes (all-cause mortality and myocardial infarction) in studies published from July 2013 to November 2021. Studies published until June 2013 have been included in a prior pooled meta-analysis which demonstrated that late preoperative discontinuation of P2Y12 receptor inhibitors (>5 days) was associated with a 2.5-fold and 1.5-fold increased risk of reoperation for bleeding and death, respectively, as compared with early (≥5 days) preoperative discontinuation.22

Although not yet validated regarding the risk of CABG-associated morbidity and mortality, we decided to use the BARC-4 bleeding definition because BARC bleeding has been introduced as a standardised bleeding endpoint for patients receiving antithrombotic therapy.22

To fill the gaps in the knowledge as outlined above, we will aim to conduct a individual patient data meta-analysis (IPD-MA). The primary objective will be to assess the incidence of BARC-4 bleeding depending on type of P2Y12 receptor inhibitors and drug-specific preoperative withdrawal period. Furthermore, the effect of preoperative P2Y12 receptor inhibitors on in-hospital/30-day all-cause mortality and myocardial infarction in on-pump CABG patients will be evaluated. We will correct for demographic and procedural variables and we will perform subgroup analyses to identify the influence of preoperative anaemia and non-emergent CABG versus urgent/emergent CABG on outcome.
METHODS AND ANALYSES

The review will be reported according to the Preferred Reporting Items for Systematic Review and Meta-Analyses of individual participant data (PRISMA-IPD) Statement.23

Sources of evidence and search strategy

We will search PubMed (July 2013 to November 2021, search strategy see table 1) and EMBASE (2014–2021, search strategy see table 2) for a combination of terms, MeSH terms and their synonyms in titles and abstracts like ‘clopidogrel’, ‘prasugrel’, ‘ticagrelor’, ‘dual antiplatelet’, ‘P2Y12 receptor inhibitor’, ‘P2Y12 receptor antagonist’, ‘CABG’, ‘bleeding’, ‘haemorrhage’. Vocabulary and syntax will be adjusted across databases. This strategy was reviewed by a librarian of the Medical University of Graz. Two researchers (IL and MS) will search separately according to the search strategy as described in tables 1 and 2. We will also search the Cochrane Library and will carry out a hand search. Unpublished ongoing clinical studies will be searched from WHO International Clinical Trials Registry Platform, ClinicalTrials.gov and Prospero (until November 2021).

Inclusion and exclusion criteria

We will include randomised controlled trials (RCTs) and observational trials that evaluate the effect of different P2Y_{12} receptor inhibitors (clopidogrel, prasugrel and ticagrelor) and drug-free period prior to surgery on any of the defined outcome measures (BARC-4 bleeding, mortality, non-fatal myocardial infarction), to assess differences depending on

1. The individual P2Y_{12} receptor inhibitor.
2. Preoperative withdrawal time.

We will include adult female and male patients of any age undergoing on-pump CABG during DAPT with aspirin and a P2Y_{12} receptor inhibitor.

Inclusion criteria are

► Full text articles in English.

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### Table 1 Search strategy for PubMed

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</tr>
<tr>
<td>#2</td>
<td>(cabg OR cardiac surgery OR coronary artery bypass OR Coronary artery surgery OR Coronary bypass surgery OR heart surgery OR “on pump” OR on-pump OR Coronary revascularization OR Coronary revascularisation OR myocardial revascularization OR myocardial revascularisation OR ((coronary OR cardiac) AND (bypass OR surgery OR surgical OR operation OR operative)) OR Coronary Artery Bypass [MeSH] OR myocardial revascularisation [MeSH])</td>
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<tr>
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<td>#1 AND #2 AND #3</td>
</tr>
<tr>
<td>#5</td>
<td>#4 AND July 2013–November 2021</td>
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### Table 2 Search strategy for Embase

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</tr>
<tr>
<td>#2</td>
<td>cabg OR cardiac surg* OR coronary artery bypass OR Coronary artery surg* OR coronary surgery OR Coronary bypass surg* OR heart surg* OR on pump OR on-pump OR Coronary* revasculari* OR myocardial revasculari*</td>
</tr>
<tr>
<td>#3</td>
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<tr>
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<td>#8</td>
<td>#7 AND 2014–current</td>
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</table>
► Isolated on-pump CABG.
► Patients on DAPT (irrespective of type of P2Y₁₂ inhibitor) with the withdrawal period being equal to or shorter than 7 days.
► At least one BARC-4 criteria documented.

Exclusion criteria are
► Off-pump CABG.
► Complex surgery (eg, CABG+valve).
► Timing of surgery based on preoperative platelet function.

Intervention
Intervention: CABG with a drug-specific preoperative withdrawal time of P2Y₁₂ receptor inhibitors (clopidogrel, prasugrel or ticagrelor) shorter than suggested by ESC and AHA/ACC guidelines.

Comparison: CABG with a drug-specific preoperative withdrawal period of P2Y₁₂ receptor inhibitors (clopidogrel, prasugrel or ticagrelor) according to the ESC and AHA/ACC guidelines.

OUTCOMES
Primary outcome
BARC-4 bleeding, defined as any of the following:22
(A) Perioperative intracranial bleeding within 48 hours, (B) reoperation after closure of sternotomy for the purpose of controlling bleeding, (C) transfusion of 5 units or more of packed RBCs within 48 hours or (D) 24-hour chest tube drainage of 2000 mL or more.

Secondary outcomes
► Mortality (in-hospital mortality/30-day mortality).
► Ischaemic end points defined according to the Academic Research Consortium-2 Consensus Document comprising death, myocardial infarction and stent thrombosis.24

Languages
English.

Time
Study start April 2021; anticipated study end March 2023.

STUDY RECORDS
Data management
All search results will be downloaded into a compatible version of MS Excel (MS Office Professional Plus 2016) from the interfaces. We will transfer these results into a common Excel file for deduplication. For manual deduplication we will have two criteria, title and author, to unambiguously recognise duplicates. Finally, we will do a cross check of the number of included studies.

Selection process
Using the results of the above searches, two authors (IL and MS) will independently screen all titles and abstracts for eligibility. Each of the two authors will document the reason for exclusion of each trial to be excluded. All records deemed potentially relevant by at least one author will be obtained in full text format and assessed according to eligibility criteria independently by IL and MS. In a second step, these evaluations will be discussed with a third researcher (EM) to resolve disagreements. The selection process will be plotted in a flow diagram in accordance with the PRISMA-P statement (figure 1).23 25

Figure 1 Flow chart diagram presenting the selection of articles for systematic review and meta-analysis of incidence of BARC-4 bleeding depending on type of P2Y₁₂ receptor inhibitor and preoperative withdrawal period. BARC, Bleeding Academic Research Consortium.

Data extraction and management
We will independently extract study characteristics such as study design (RCTs, observational trials), authors, year of publication and setting of study. We will aim to perform an IPD-MA for the review questions because the main outcome of interest, BARC-4 bleeding, is not generally reported in the literature. IPD-MA would furthermore allow for the direct incorporation of demographic and procedural variables that were previously identified as potential confounders of increased bleeding into the analysis.7 16 26

Following the selection process, we will address the first author or, if unavailable, the corresponding author of each identified study. All authors will be asked to provide a selection of parameters from their original datasets in a
In a pseudonymised fashion that does not allow identification of individual identities. We will provide an Excel sheet outlining the requested parameters (see Table 3). After accepting the invitation to collaborate and signing both a confidentiality and data transfer agreement, the authors will be asked to share their data via a secure server of the Medical University of Graz. This uploading process is encrypted. The stored data will be protected by access authorisation. The received data will be reviewed to assess the completeness and accuracy of the dataset.

Plausibility checks of the received data will be performed by comparing summary measures of the IPD with the published data as well as by checking plausibility of the individual values in a clinical context. Any implausibilities will be resolved with the original authors through queries. Individual datasets will be preprocessed and merged into

<table>
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<td>Euroscore 2</td>
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<td>UFH or LMWH or fondaparinux (within 24 hours preop)</td>
<td>y/n</td>
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*Part of euroscore II.
†If unavailable chest tube drainage volume obtained during shorter observation period (define observation period).
ASS, Aspirin; BMI, body mass index; CABG, coronary artery bypass grafting; CAD, Coronary Artery Disease; CPB, Cardiopulmonary Bypass; Hb, Haemoglobin; LMWH, Low Molecular Weight Heparin; LVEF, Left ventricular ejection fraction; MI, Myocardial infarction; NSTEMI, Non-ST-Elevation Myocardial Infarction; STEMI, ST-Elevation Myocardial Infarction; UFH, Unfractionated heparin.
a single datafile for analysis. At the end of the study, all original individual datasets will be deleted.

**RISK OF BIAS**

Two authors (IL and MS) will assess the risk of bias for each trial independently. Possible disagreements will be resolved by consensus, or with consultation of a third party (EM).

For RCTs, we will assess risk of bias using the Cochrane Collaboration’s tool. We will use the following bias criteria:
► Random sequence generation (selection bias).
► Allocation concealment (selection bias).
► Blinding (performance bias and detection bias), separately for blinding of participants and personnel and blinding of outcome assessment.
► Incomplete outcome data (attrition bias).
► Selective reporting (reporting bias).
► Other bias.

We will judge risk of bias criteria as ‘low risk’, ‘high risk’ or ‘unclear risk’ as described in the Cochrane Handbook for Systematic Reviews of Interventions.

For observational studies, the quality of each study will be assessed using the Robins-I Tool as suggested by the Cochrane Handbook for Systematic Reviews of Interventions.

The following domains will be assessed:
► Bias due to confounding.
► Bias in selection of participants into the study.
► Bias in classification of interventions.
► Bias due to deviations from intended interventions.
► Bias due to missing data.
► Bias in measurement of outcomes.
► Bias in selection of the reported result.

**DATA SYNTHESIS**

The primary analysis will be performed as a two-stage IPD-MA. For this approach, each study will first be individually analysed according to a prespecified regression model for each type of P2Y12 inhibitor including drug specific preoperative withdrawal time as well as relevant confounders (see table 3). The results of these analyses will be presented as odds ratios (OR) and 95% confidence intervals (CI) and can be displayed in a forest plot. For the second stage, these results will be pooled using standard meta-analytic methods, in our case random-effects models.

If we cannot get individual patient data for all identified studies, the risk of availability bias will be assessed by comparing study characteristics of those providing data and those that do not. For studies not providing individual patient data but presenting the respective outcomes, we will incorporate these results in a sensitivity analysis to test the robustness of the IPD findings. Furthermore, the equivalent to the well-known Funnel plot will be visually assessed.

Additionally, subgroup analyses are planned for:
► Patients undergoing non-emergent CABG versus patients undergoing urgent/emergent CABG because of ACS.
► Patients preoperatively presenting with anaemia according to the WHO-definition of less than 13 g/dL for men and less than 12 g/dL for women versus preoperatively non-anaemic patients.

Furthermore, sensitivity analyses will test the robustness of our findings for the analysis of the primary outcome. They will be performed for study quality and drug-specific preoperative withdrawal periods for each single day of withdrawal, including no preoperative withdrawal.

The analyses will be performed using a current version of R. No imputation for missing data is planned. The analyses are performed in accordance with the handbook of the Cochrane collaboration and results will be presented according to the PRISMA-IPD statement.

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**Contributors**

MS: study design, bibliographic research, design of data entry forms, data management, conduct of study, protocol and manuscript writing. GP: study design, data management, statistical analysis, protocol and manuscript writing and review. AB: study design, statistical analysis, protocol and manuscript writing and review. IL: bibliographic search, design of data entry forms, data management, conduct of study, protocol and manuscript review. RZ: Scientific coordination, protocol and manuscript writing and review. AV: Scientific coordination, protocol and manuscript review. EM: study design, scientific coordination, protocol and manuscript writing and review. AZ: Scientific coordination, protocol and manuscript review

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**Competing interests**

AZ received honoraria for lectures and consulting of Daiichi Sankyo, Lilly, AstraZeneca, Bristol Myers Squibb, Pfizer, Bayer, Boehringer Ingelheim.

**Patient and public involvement**

Patients and/or the public were not involved in the design, or conduct, or reporting, or dissemination plans of this research.

**Patient consent for publication**

Not applicable.

**Provenance and peer review**

Not commissioned; externally peer reviewed.

**Open access**

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