No evidence for a prethrombotic state in stable chronic inflammatory bowel disease

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SUMMARY Ulcerative colitis and Crohn’s disease are associated with a high risk of thromboembolic complications. The questions whether reported risk factors such as low antithrombin III concentrations, thrombocytosis and spontaneous platelet aggregation are merely related to the activity of the inflammatory process remains to be answered. Therefore we investigated 40 patients with an established colitis or Crohn’s disease, without signs of active inflammation (normal history, normal ESR and leucocyte count). Of these patients only one patient revealed thrombocytosis, six patients spontaneous platelet aggregation. All patients had normal β-thromboglobulin and platelet factor 4 plasma levels. No other prethrombotic abnormalities were encountered. There was normal factor VIII C (increased in three patients), normal VIII C/VIII R Ag ratio (1.2), antithrombin III, normal plasminogen and normal α2-antiplasmin. Normal fibrinopeptide A and Bβ (15-42) plasma levels (n = 15) in these patients excluded in vivo thrombin or plasmin generation. We conclude that stable chronic inflammatory bowel disease is in general not associated with prethrombotic coagulation abnormalities.

The course of inflammatory bowel disease is variably complicated by thromboembolic disease. The reported incidence varies between 1-2 and 39%. This wide range is due to lower incidences reported in clinical studies (1-2-7.5%)1-3 versus higher incidences in necropsy studies (6-6-39%).4 The obvious bias in these studies is the selection procedure of patients. Most reports concern severely ill patients in an active terminal stage of inflammatory bowel disease.

That inflammatory bowel disease predisposes to thromboembolic disease is weakly substantiated by studies claiming a wide range of coagulation and platelet abnormalities suggestive of a “prethrombotic state.” Only a few investigations report on factors implying a real risk for thromboembolism, such as an acquired antithrombin-III deficiency.5 6

Deficiency of this important coagulation inhibitor is generated in inflammatory bowel disease by intestinal protein loss. Due to modern diagnostic means and increased therapeutic potential severely ill inflammatory bowel disease patients are now less frequently admitted. Also a reduction of thromboembolic complications have been observed in these patients.

It is therefore of interest to reinvestigate inflammatory bowel disease patients in a defined stable condition using selected methods which provide data on in vivo activation of the coagulation system and/or of platelets.

Material and methods

Forty inflammatory bowel disease patients (mean age 33-9 yr, range 17-54 yr) under control of our outpatient department of gastroenterology were studied. Twenty-six patients were diagnosed as having ulcerative colitis and 14 Crohn’s disease. The diagnosis was made on clinical criteria and confirmed by x-ray, endoscopy and histology on biopsy specimen.

All patients were in a stable remission phase of their disease. This was determined by using the activity index of van Hees et al7 and of Truelove et al.8 Patients with Crohn’s disease were considered to be in the non-active phase with an index value below 100, or considered mild in the case of ulcerative colitis.

Of the group of patients with ulcerative colitis, 17 patients had local involvement of the colon, six
patients had involvement of the entire colon and three patients had only rectum lesions. Two patients underwent surgery; proctocolectomy, hemicolec-
tomy respectively.

Of patients with Crohn’s disease, seven had lesions on the distal part of ileum, two patients had lesions in the colon as well as in the ileum, three had Crohn’s disease of the colon and two patients had anorectal lesions. Four patients of this group had small bowel resection in their history, and one patient underwent a hemicolec-
tomy.

Ten ulcerative colitis patients and five Crohn’s disease patients did not receive any therapy. The remaining patients received salazopyrine and corticosteroids.

Besides the general patient history, a detailed case history on thromboembolic complications was obtained. Additional clinical information and informed consent were obtained from all patients prior to the study.

LABORATORY INVESTICATIONS

General coagulation and fibrinolytic tests
Venous blood was collected using a 20 gauge Was-
serman needle in plastic tubes containing either solid K₂EDTA (1.5 mg/ml blood) or trisodium-
citrate dihydrate 3-2% (one volume to 9 volumes of
blood).

Plasma was prepared by centrifugation for 10 min
at 1700 g followed by a second run at 12 000 g.
EDTA-plasma was used for the automated
chromogenic determination of factors II, X, anti-
thrombin III, plasminogen and α₁-antiplasmin. 10–14
Citrate-plasma was used for the assay of factors V, 15
VIII, VIIIIR Ag 17 and fibrinogen. 18

A plasma mixture (40 donors, sex ratio 1:1) was the reference for the one stage factor V and VIIIC
coaagulation assays. Normal ranges for all assays
were obtained in 176 ostensibly healthy subjects
(mean age 35 yr, range 10–62 yr).

Tests measuring activated coagulation and
fibrinolytic pathways: fibrinopeptide A and
Bβ 15-42
Blood (2-7 ml) was collected in polystyrene tubes
containing 0-3 ml heparin (1000 U/ml, Kabi Vitrum,
Stockholm, Sweden) and Trasylo‡ (1000 U/ml,
Bayer, Leverkusen, FRG) in 3-8% trisodium
citrate dihydrate. Plasma was prepared immediately
by centrifugation at 4°C followed by precipitation in
duplicate of 0-4 ml in 0-4 ml icecold polyethylene-
glycol (PEG 6000, Merck FRG) 40% in phosphate-buffered
saline. Supernatants were heated for 2 min at 100°C to precipitate residual
traces of fibrinogen. The radioimmunoassay on the
supernatant for fibrinopeptide A was essentially per-
formed as described. 19

All samples were analysed using antiserum 44656
and antiserum 6216 with different specificity which
will be published in detail elsewhere. Their reactiv-
ity with FPA (Aα 1-16) is identical and taken as
100%, then their reactivity with fibrinogen is 30% and < 0.5%, with plasmin-induced fibrinogen
fragments 30–80% and < 0.5%, with granulocytic
proteases-induced fibrinogen fragments 30–100% and 0–3% respectively.

Concentrations in 60 healthy control subjects
were in a range of 0–2 ng/ml. The peptide Bβ 15-42
was measured after the PEG precipitation proce-
dure using the commercial kit (batch B 132-1,
IMCO Corporation, Stockholm, Sweden).

Platelet tests
Platelets were counted using the Coulter Cell
counter 134 (Analytic Instruments, Sweden).

Spontaneous platelet aggregation and aggregation
upon challenging with 0.1 μg/ml adenosine dipho-
sphate (ADP) were performed as described before. 20

The platelet release products β-thromboglobulin
(β-TG) and platelet-factor-4 were measured in plasma according to Ludlam and Cash 21 using com-
mercially available RIA test kits (Radiochemical
Centre, Amersham, Bucks).

Results

One patient with ulcerative colitis had a history of a
pulmonary embolism during the period of bedrest
after proctocolectomy. At that time he was treated
with subcutaneous heparin as antithrombotic prophylaxis.

One patient developed deep vein thrombosis of
his leg during an exacerbation of his Crohn’s dis-
 ease.

The other patients experienced no such complica-
tions. The inflammation related parameters ESR,
hemoglobin, leucocyte counts and albumin con-
centrations were normal in all patients and
confirmed the stable remission phase.

General coagulation and fibrinolytic parameters
All coagulation factors (Table) were within the
normal range except in three patients who had mild
deficiencies of factor II (0-62 U/ml), factor X (0-64
U/ml) and factor V (0-66 U/ml) respectively.

Three patients had raised concentrations of factor
VIIIIC. The mean ratio F VIIIIC/factor VIIIIR Ag was
1:2 (ratio in control subjects 1:1). Antithrombin III
and fibrinolytic parameters were in the normal range
except in one patient who had a slightly decreased
plasminogen level.
Test measuring activated coagulation and fibrinolytic pathways

Fibrinopeptide A with both antisera and B\(\beta\) 15-42 showed normal levels in the 15 patients investigated (Table).

Platelet count and functions

Only one patient showed a mild thrombocytosis. Spontaneous platelet aggregation was encountered in six patients who showed also hyperaggregation upon challenging with ADP.

In 15 patients \(\beta\)-TG and platelet-factor-4 levels were within the normal range (Table).

Discussion

Thromboembolism is still an accepted complication of inflammatory bowel disease. Main causes are considered to be dehydration, immobilisation and activity of the disease. Whether a so-called hypercoagulative state contributes remains to be solved. Thus far several investigators have demonstrated increased levels of factor V, VIII and of fibrinogen.\(^{6,28}\) It is most uncertain that this implies an increased risk for thrombosis.

Other studies revealed an acquired deficiency of antithrombin-III in active inflammatory bowel disease patients which was found to return to normal upon clinical remission.\(^{6}\) At present this is the only real risk factor for thrombosis thus far reported. Acquired antithrombin-III deficiency has indeed an associated risk for spontaneous thrombotic events.\(^{22}\) In order to establish the occurrence of risk factors for thromboembolic disease we investigated inflammatory bowel disease patients in a stable remission of their disease as judged by activity indices.\(^{8,9}\) We did not observe major changes in coagulation, fibrinolytic factors and of the respective inhibitors antithrombin-III and of \(\alpha_2\)-antiplasmin. Since conventional coagulation assays do not necessarily reflect activation of blood coagulation, sensitive tests for the detection of activation of blood coagulation such as fibrinopeptide A and of fibrinopeptide B\(\beta\) for the detection of plasmin activity in vivo were employed. All patients showed normal levels of fibrinopeptide A (Fpa) immunoactivity, as determined with both antisera. This excluded substantial intravascular thrombin activity or influx of Fpa (Aa-16) from the inflammatory site into the circulation. In addition, as antisera 6216 cross-reacts with plasmin or granulocytic protease-induced fibrinogen fragments, a major contribution of these enzymes to intravascular and presumably extravascular fibrinogenolysis becomes unlikely. The observation of the absence of B\(\beta\) (15-42) immunoreactivity in the plasma of these patients strengthens this conclusion.

Thrombocytosis and shortened platelet survival in inflammatory bowel disease may be considered as a risk factor for arterial thrombotic complications such as stroke.\(^{5,7,23-27}\)

Spontaneous platelet aggregation was found in six of 40 patients, which is in agreement with other observations.\(^{28}\) This finding is possibly relevant for the pathogenesis of arterial thrombotic events, but of most uncertain relevance for the pathogenesis of venous thromboembolism. Also tests for blood platelet activation c.q. circulating platelet release products were included in this study and showed no raised plasma levels of \(\beta\)-TG or platelet-factor-4 which excludes excessive intravascular consumption of platelets.

In conclusion it should be stressed that inflammatory bowel disease should be considered in two separate phases, the acute active and the non-active phase. From our data in patients in the non-active phase of their disease it is concluded that no evidence for the existence of a prethrombotic state is demonstrated.
References


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