Cardiac Troponin I Predicts Short-Term Mortality in Vascular Surgery Patients

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Background—Cardiac troponin I (cTnI) is a highly sensitive and specific marker for myocardial injury that predicts outcomes in patients with acute coronary syndromes. Cardiovascular complications are the leading cause of morbidity and mortality in patients who have undergone vascular surgery. However, postoperative surveillance with cardiac enzymes is not routinely performed in these patients. We evaluated the association between postoperative cTnI levels and 6-month mortality and perioperative myocardial infarction (MI) after vascular surgery.

Methods and Results—Two hundred twenty-nine patients having aortic or infrainguinal vascular surgery or lower extremity amputation were included in this study. Blood samples were analyzed for cTnI immediately after surgery and the mornings of postoperative days 1, 2, and 3. An elevated cTnI was defined as serum concentrations >1.5 ng/mL in any of the 4 samples. Twenty-eight patients (12%) had postoperative cTnI >1.5 ng/mL, which was associated with a 6-fold increased risk of 6-month mortality (adjusted OR, 5.9; 95% CI, 1.6 to 22.4) and a 27-fold increased risk of MI (OR, 27.1; 95% CI, 5.2 to 142.7). Furthermore, we observed a dose-response relation between cTnI concentration and mortality. Patients with cTnI >3.0 ng/mL had a significantly greater risk of death compared with patients with levels ≤0.35 ng/mL (OR, 4.9; 95% CI, 1.3 to 19.0).

Conclusions—Routine postoperative surveillance for cTnI is useful for identifying patients who have undergone vascular surgery who have an increased risk for short-term mortality and perioperative MI. Further research is needed to determine whether intervention in these patients can improve outcome. (Circulation. 2002;106:2366-2371.)

Key Words: cardiovascular diseases complications surgery
specific aim of this study was to evaluate the association between postoperative cTnI levels and 6-month mortality and perioperative MI in patients who have undergone vascular surgery.

Methods

Study Population

After approval from the institutional review board, informed consent was obtained from 229 patients undergoing aortic or infrainguinal vascular surgery or lower extremity amputation between June 1997 and September 1999 at the Johns Hopkins Hospital (Baltimore, Md). These patients were part of a clinical trial designed to evaluate the efficacy of early detection (using continuous 12-lead ECG monitoring) and treatment of myocardial ischemia for reducing cardiac complications. All patients were monitored for ischemia by computerized ST-segment analysis for the first 48 hours after surgery and had ECGs at baseline and for the first 2 postoperative days according to American College of Cardiology/American Heart Association guidelines. Standard perioperative treatment included the routine use of β-blockers. Exclusion criteria for the trial included age <40 years, a left bundle-branch block on a preoperative ECG, a permanent pacemaker, and emergency procedures.

Outcome Variables

The main dependent variable was 6-month mortality. To evaluate this end point, patients were followed through surgery and contacted for a phone interview at 6 months. In patients who died during the index or subsequent hospitalization, cause of death was classified by 2 independent investigators as cardiovascular disease versus “other,” based on a review of clinical data, including death certificates and autopsy reports. For patients whose telephone number was not accurate, we ran a search in the social security death index. The main dependent variable was perioperative MI. MI diagnosis was made by the primary care team according to standard World Health Organization criteria or by autopsy findings during the course of routine clinical care.

Exposure Variable: Cardiac Troponin I

Blood specimens were analyzed for cTnI immediately after surgery and the morning of postoperative days 1, 2, and 3. These time points were chosen because patients are at greatest risk for cardiac complications during the first 72 hours after vascular surgery. The single highest cTnI concentration was used as the exposure variable, and patients were considered to have an elevated cTnI if the peak serum level was >1.5 ng/mL, the manufacturer-recommended cutoff for MI diagnosis. The detection limit of the immunoassay was 0.35 ng/mL. cTnI assays were performed in the hospital core laboratory with the use of the Stratus fluorometric enzyme immunoassay (Dade Pharmaceuticals), which uses two monoclonal antibodies that are specific for the cardiac isotype of troponin I. The primary clinical team was blinded to the cTnI results obtained as part of the study protocol.

In a supplementary analysis, we investigated a dose-response relation between cTnI and 6-month mortality by stratifying peak cTnI concentrations into 4 groups: ≤0.35 ng/mL (virtually no cTnI detected in serum), 0.4 to 1.5 ng/mL (moderate elevations), 1.6 to 3.0 ng/mL (significant elevations consistent with the definition of an MI), and >3.0 ng/mL (elevations more than twice that required for MI diagnosis). The ≤0.35 ng/mL group was the reference category to which the other groups were compared.

Statistical Analysis

In the univariate analysis of baseline characteristics, dichotomous variables were compared by means of a χ² test or Fischer’s exact test where appropriate, and continuous variables were compared by means of a Student’s t test. For the primary dependent variable, multivariate analysis was performed with logistic regression, with cTnI modeled as a dichotomous variable. Estimated odds ratios and corresponding 95% confidence intervals and probability values are reported.

We examined survival time after surgery by constructing actuarial curves using the Kaplan-Meier method. Survival at 6 months between groups with peak cTnI levels greater than and less than or equal to 1.5 ng/mL was compared by means of the log rank test. To investigate an association between postoperative cTnI levels and perioperative MI diagnosis, we created a 2×2 contingency table of the exposure and outcome variables and calculated an estimate of the odds ratio and 95% CI by using the Woolf procedure. Probability values <0.05 were considered statistically significant, and all analyses were performed with STATA 6.0.

Results

Baseline Characteristics

Twelve percent of patients (28 of 229) had peak cTnI levels >1.5 ng/mL after surgery. Of these patients, the majority of peak cTnI values occurred on postoperative days 1 (46%) and 3 (36%). The frequency was 11% and 7% on postoperative days 2 and 0, respectively. Of 9 patients who were dialysis-dependent before surgery, 2 had elevated cTnI levels. Comparison of baseline characteristics between patients with cTnI levels above and below the diagnostic cutoff is presented in Table 1. Diabetes was the only preoperative predictor of an elevated cTnI. Fifty percent of patients in the cTnI >1.5 ng/mL group had diabetes compared with 26% in the cTnI ≤1.5 ng/mL group (OR, 2.8; 95% CI, 1.2 to 6.2). Thoracoabdominal aortic aneurysm repair, compared with all other
Compared with those with cTnI levels below the diagnostic threshold, patients with cTnI levels above the diagnostic threshold had a 4-fold increase in mortality risk (OR, 4.2; 95% CI, 1.4 to 12.4). After controlling for other covariates in the adjusted model, the risk increase was 6-fold (OR, 5.9; 95% CI, 1.6 to 22.4). Other multivariate predictors of mortality included history of congestive heart failure (OR, 12.0; 95% CI, 3.3 to 44.2), thoracoabdominal aortic aneurysm repair (OR, 5.8; 95% CI, 1.5 to 23.3), and age <75 years (OR, 1.2 per year; 95% CI, 1.0 to 1.4). Although patients who died were older than those who were alive at 6 months (76±7 years versus 69±10 years; P<0.001), the mortality risk was significantly greater in younger patients as the result of a nonlinear relation between age and death, with a break at 75 years. Similar to previous studies,8,9 perioperative β-blockade was associated with a significant reduction in short-term mortality (OR, 0.3; 95% CI, 0.1 to 0.9).

There was a dose-response relation between cTnI concentration and 6-month mortality (Figure 1). Peak cTnI levels were ≤0.35 ng/mL in 57% (n=128), between 0.4 and 1.5 ng/mL in 31% (n=70), between 1.6 and 3.0 ng/mL in 4% (n=10), and >3.0 ng/mL in 8% (n=18) of patients. Six-month mortality rates in these groups were 5%, 7%, 20%, and 22%, respectively. CTnI >3.0 ng/mL was associated with a significantly increased risk for 6-month mortality compared with the lowest level group (OR, 4.9; 95% CI, 1.3 to 19.0).

A Kaplan-Meier survival curve for patients with peak cTnI levels above and below the diagnostic threshold is shown in Figure 2. Survival rates were similar in these 2 groups until ~5 weeks after surgery, after which patients with cTnI >1.5 ng/mL had a steeper decline in survival compared with patients with cTnI ≤1.5 ng/mL. At 6 months, patients with elevated cTnI had an unadjusted hazard ratio of 3.9 (95% CI,
2.0 to 37.4) for death compared with those with levels below the cutoff.

**Perioperative Myocardial Infarction**

Eight patients (3%) were diagnosed with a perioperative MI: 6 had elevated cardiac enzymes and diagnostic ECGs, 1 had chest pain in addition to elevated cardiac enzymes and diagnostic ECGs, and 1 MI was discovered at autopsy. Surveillance cTnI was elevated in 6 of these patients before or concurrent with clinical diagnosis, and all received medical intervention. At 6 months, 5 of these patients reported no invasive coronary interventions and 1 had an incomplete follow-up. Of the 2 patients who had surveillance cTnI ≤1.5 ng/mL, 1 ruled in with a positive troponin I on postoperative day 2 by means of a more sensitive second-generation assay that was in clinical use. The other patient was not diagnosed on clinical grounds but had a respiratory arrest on postoperative day 3 and was diagnosed with MI on postmortem examination.

Elevated surveillance cTnI levels were associated with perioperative MI in vascular surgery patients (OR, 27.1; 95% CI, 5.2 to 142.7) (Table 3). Of the 28 patients with cTnI >1.5 ng/mL, 6 were diagnosed with a clinical MI and 1 of these patients was dead at 6 months. Of the remaining 22 patients with elevated cTnI and not diagnosed with an MI, there were 5 deaths, the majority (4 of 5) of which occurred after hospital discharge.
TABLE 3. Predictive Value of cTnI for Perioperative MI

<table>
<thead>
<tr>
<th>cTnI</th>
<th>MI+</th>
<th>MI−</th>
<th>Unadjusted OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;1.5 ng/mL</td>
<td>6 (75%)</td>
<td>22 (10%)</td>
<td>27.1† (5.2–142.7)</td>
</tr>
<tr>
<td>≤1.5 ng/mL</td>
<td>2 (25%)</td>
<td>199 (90%)</td>
<td>. . .</td>
</tr>
</tbody>
</table>

MIIs were diagnosed by the primary clinical team using standard WHO criteria or at autopsy.
†P value<0.01.

Discussion

Elevated cTnI levels after major vascular surgery are associated with an increased risk of short-term mortality and morbidity. Patients with postoperative cTnI >1.5 ng/mL are 6 times more likely to die within 6 months of surgery compared with patients with levels ≤1.5 ng/mL, after adjusting for age, congestive heart failure, surgical procedure, and perioperative β-blockade. Moreover, we observed a dose-response relation between cTnI concentration and death. The strong association between cTnI and short-term mortality suggests that clinically meaningful postoperative ischemia may have been missed in a significant number of vascular surgery patients. More importantly, the survival analysis demonstrates that the difference in mortality associated with an elevated cTnI does not emerge until 5 weeks after surgery. Thus, routine postoperative surveillance for cTnI may alert clinicians to patients at high risk for cardiovascular complications and death before the occurrence of a morbid event. Further research is required to determine if additional evaluation and treatment of these patients at high risk can reduce morbidity.

Twelve percent of patients had cTnI elevations during routine postoperative surveillance that were associated with an increased risk of perioperative MI. This proportion is lower than the one third of patients reported to have ECG evidence of myocardial ischemia after vascular surgery, but higher than the 5% incidence of perioperative MI previously reported. Only 3% of patients in this study were identified as having a clinical MI defined by current guidelines for perioperative ischemia surveillance and WHO definitions of MI.

Perioperative cardiac injury is associated with mortality rates of 36% to 70%, However, its detection in surgical patients remains a challenge for several reasons: In the postoperative setting, MI and clinically important ischemia are often silent as a result of altered pain perception caused by residual anesthetics, analgesics, or competing incisional pain. Additionally, skeletal muscle injury sustained during surgery increases CK-MB levels, making it difficult to distinguish myocardial from skeletal muscle injury with the use of this conventional cardiac marker. cTnI, on the other hand, is useful for confirming or excluding the diagnosis of myocardial injury. Its potential utility in the perioperative risk assessment of patients who have undergone vascular surgery is particularly good because of the high prevalence of CAD and incidence of cardiac complications. Routine cTnI surveillance may improve current strategies that are used to detect perioperative myocardial ischemia and infarction.

Consistent with previous studies, we found a relation between perioperative administration of β-blockers and reduced short-term mortality. However, there was no association between β-blocker use and elevated postoperative cTnI. Furthermore, the relation between cTnI and death persisted even after adjusting for the benefits of perioperative β-blockade. Thus, surveillance cTnI appears to be an independent predictor of morbidity and mortality even in the presence of β-blockade.

Our results in surgical patients parallel previous reports of medical patients. In patients with unstable angina, elevated cTnI levels on admission are associated with a 3- to 5-fold increase in short-term morbidity and mortality. A quantitative relation between cTnI concentration and incidence of cardiac complications guides risk stratification practices, and as a screening test, cTnI has been shown to improve triage procedures for patients presenting to emergency rooms with acute chest pain. Recently, investigators of the Treat Angina with Aggrastat and Determine Costs of Therapy with an Invasive or Conservative Therapy—Thrombolysis In Myocardial Infarction/Infarction (TACTICS-TIMI) 18 trial reported a marked reduction in adverse cardiac events among cTnI-positive patients with acute coronary syndromes who were randomly assigned to an early invasive treatment strategy compared with medical treatment. Moreover, the ability of cTnI to predict a benefit from more aggressive therapy was superior to that of CK-MB elevation or ST-segment deviation. There is growing evidence in support of integrating cTnI into algorithms that guide risk assessment and treatment of patients with acute coronary syndromes. Our data suggest that inclusion of cTnI surveillance in such algorithms for vascular surgery patients may have utility as well.

We recognize several limitations of the present study. Because the primary outcome of the main study has not yet been reviewed, all cause-specific mortality data were not available for this analysis. However, based on physician review of clinical data, evidence from medical patients, and the high prevalence of CAD in patients who have undergone vascular surgery, it is likely that cardiovascular complications contributed to mortality and that additional cardiovascular evaluation would appear prudent. Furthermore, we did not determine the optimal number and timing of cTnI measurements. cTnI remains elevated for 7 to 10 days after release into circulation, which may allow screening at a single postoperative time point to identify patients who had myocardial injury. It remains unclear which screening strategy would be most cost-effective for identification of high-risk surgical patients. Last, although 75% of our patients received β-blockers during surgery, β-blocker use was not universal. Thus, it is possible that the 12% incidence of elevated cTnI we observed is higher than what may occur in the presence of universal β-blockade. Nonetheless, even when β-blocker therapy has been universally applied in clinical trials, cardiac morbidity and mortality have not been eliminated.

In conclusion, elevated cTnI levels after major vascular surgery are associated with a significantly increased risk of 6-month mortality and perioperative MI. Moreover, we ob-
served a dose-response relation between cTnI concentration and death. Postoperative cTnI levels provide important prognostic information, and routine surveillance is useful for identifying patients who have an increased risk for morbidity and mortality. Further research is needed to determine whether intervention in patients with elevated cTnI can improve outcome.

Acknowledgments

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References

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