Thrombolysis Compared With Heparin for the Initial Treatment of Pulmonary Embolism
A Meta-Analysis of the Randomized Controlled Trials

Susan Wan; Daniel J. Quinlan, MBBS; Giancarlo Agnelli, MD; John W. Eikelboom, MBBS

Background—Randomized trials and meta-analyses have reached conflicting conclusions about the role of thrombolytic therapy for the treatment of acute pulmonary embolism.

Methods and Results—We performed a meta-analysis of all randomized trials comparing thrombolytic therapy with heparin in patients with acute pulmonary embolism. Eleven trials, involving 748 patients, were included. Compared with heparin, thrombolytic therapy was associated with a nonsignificant reduction in recurrent pulmonary embolism or death (6.7% versus 9.6%; OR 0.67, 95% CI 0.40 to 1.12, \(P\) for heterogeneity \(=0.48\)), a nonsignificant increase in major bleeding (9.1% versus 6.1%; OR 1.42, 95% CI 0.81 to 2.46), and a significant increase in nonmajor bleeding (22.7% versus 10.0%; OR 2.63, 95% CI 1.53 to 4.54; number needed to harm \(=8\)). Thrombolytic therapy compared with heparin was associated with a significant reduction in recurrent pulmonary embolism or death in trials that also enrolled patients with major (hemodynamically unstable) pulmonary embolism (9.4% versus 19.0%; OR 0.45, 95% CI 0.22 to 0.92; number needed to treat \(=10\)) but not in trials that excluded these patients (5.3% versus 4.8%; OR 1.07, 95% CI 0.50 to 2.30), with significant heterogeneity between these 2 groups of trials (\(P=0.10\)).

Conclusions—Currently available data provide no evidence for a benefit of thrombolytic therapy compared with heparin for the initial treatment of unselected patients with acute pulmonary embolism. A benefit is suggested in those at highest risk of recurrence or death. The number of patients enrolled in randomized trials to date is modest, and further evaluation of the efficacy and safety of thrombolytic therapy for the treatment of high-risk patients with acute pulmonary embolism appears warranted. (Circulation. 2004;110:744-749.)

Key Words: embolism • meta-analysis • thrombolysis • heparin

Pulmonary embolism remains a major cause of morbidity and mortality in the general community, with an estimated incidence of 0.5 per 1000 people\(^1\) and a case-fatality rate of 15% at 3 months.\(^2\) Mortality is even higher for patients with “major” pulmonary embolism; registry data indicate in-hospital mortality of up to 30% in patients with acute pulmonary embolism who are hemodynamically unstable at presentation.\(^3,4\)

The established treatment for acute pulmonary embolism is anticoagulation with unfractionated or low-molecular-weight heparin,\(^5\) followed by at least 3 to 6 months of warfarin.\(^6\) Thrombolytic therapy has also been evaluated for the initial treatment of major pulmonary embolism, but its role remains controversial.\(^7\) Despite favorable effects of thrombolysis on angiographic, hemodynamic, and scintigraphic measures, the majority of studies comparing thrombolysis with heparin have not demonstrated a reduction in recurrent venous thromboembolism or death\(^8,9\) but have demonstrated an increase in bleeding.\(^10\)

Three recently published meta-analyses\(^11–13\) and 1 large randomized trial\(^14\) have prompted further debate about the role of thrombolysis for the initial treatment of pulmonary embolism.\(^15–17\) Two of the meta-analyses pooled data from the same 9 randomized trials, yet they came to conflicting conclusions about the benefits of thrombolysis compared with heparin for the initial treatment of pulmonary embolism.\(^12,13\) The randomized trial by Konstantinides et al\(^14\) is the largest trial to date to compare thrombolysis with heparin for the initial treatment of pulmonary embolism; however, it remains underpowered to reliably detect a modest yet worthwhile reduction in pulmonary embolism or death with thrombolytic therapy compared with heparin.\(^14\)

To further clarify the role of thrombolysis for the treatment of pulmonary embolism, we performed an updated meta-analysis of all properly randomized trials comparing thrombolysis with heparin for the initial treatment of acute pulmonary embolism.
Methods
A protocol was developed prospectively that detailed the specific objectives, criteria for study selection, the approach to assessing study quality, clinical outcomes, and statistical methodology.

Study Identification
We attempted to identify all relevant published and unpublished randomized trials comparing thrombolysis with heparin for the initial treatment of pulmonary embolism. We searched electronic databases (MEDLINE and EMBASE) from January 1980 to January 2003 and the Cochrane Library (2003, Issue 1) using the terms "pulmonary embolism," "thromboembolism," "thrombolysis," "fibrinolysis," "randomized controlled trial," "controlled clinical trial," and "random" in combination with generic and trade names of individual thrombolytic agents. We also hand searched bibliographies of journal articles and abstracts from major international meetings.

Study Selection
Two investigators (S.W., J.W.E.) independently evaluated studies for inclusion, and any disagreements were resolved by discussion. Criteria for inclusion were (1) proper randomization, (2) inclusion of patients with objectively diagnosed symptomatic pulmonary embolism, (3) comparison of thrombolysis with heparin for the initial treatment of pulmonary embolism, and (4) use of objective methods to assess 1 or more clinical outcomes, including pulmonary embolism, death, and bleeding.

Assessment of Study Quality
We adopted the criteria for study quality outlined by Schultz and colleagues and Eikelboom et al in the evaluation of studies included in the present meta-analysis. These criteria include (1) proper generation of the treatment allocation sequence, (2) proper concealment of the allocation sequence, (3) blinding of the patient and the investigator assessing clinical outcomes to treatment allocation, and (4) completeness of follow-up.

Data Extraction
Two investigators (S.W., J.W.E.) independently extracted data on study design, study quality, and the following efficacy and safety outcomes during hospitalization or within 30 days: (1) pulmonary embolism; (2) death; (3) major bleeding; (4) nonmajor bleeding; and (5) intracranial hemorrhage.

Outcomes
The primary efficacy outcome was the composite of recurrent pulmonary embolism or death. Secondary outcomes were the individual components of the primary outcome, and safety outcomes were major bleeding, nonmajor bleeding, and intracranial hemorrhage.

Statistical Analysis
We used a fixed-effects model based on the Mantel-Haenszel method for combining results from the individual trials. All statistical calculations were performed with Comprehensive Meta Analysis, version 1.0.23 (Biostat; 1998). Subgroup analyses were performed to explore the treatment effect of thrombolytic therapy compared with heparin in trials that included patients with major (hemodynamically unstable) pulmonary embolism versus trials that excluded these patients.

Sensitivity analyses were conducted to explore the robustness of our results. To identify any study that may have exerted a disproportionate influence on the summary treatment effect, we deleted studies one at a time. We examined the effect of excluding lower-quality studies from the analysis. An inverted funnel plot of treatment effect versus study precision was created for the primary outcome to look for possible publication bias. Results obtained with a fixed-effects model were also compared with those obtained with a random effects model. A probability value of less than 0.05 was considered statistically significant except for heterogeneity testing, for which statistical significance was accepted at a probability value of 0.10.

Results

Study Selection
The process of study selection is outlined in Figure 1. Our search identified 700 potentially eligible citations. After their titles and abstracts were scanned, 34 were retained for further evaluation. Seventeen studies (including 1 published only in abstract form) were nonhuman, nonrandomized, and/or evaluated the use of surgical or percutaneous mechanical thrombolysis. These studies were excluded. Six reported identical or long-term follow-up data on patients or subgroups of patients previously or subsequently included in other or more complete reports. These studies were also excluded, which left a total of 11 studies for inclusion in the present meta-analysis.

Study Design
The designs of studies included in the meta-analysis are summarized in Table 1. All 11 studies included patients with symptomatic pulmonary embolism; however, patients with major pulmonary embolism (hemodynamic instability) were eligible for inclusion in only 5 trials.

Study Quality
Reporting of study quality data was incomplete. Randomized treatment allocation sequences were generated with random number tables or programs in 3 studies. Information about proper concealment of the treatment allocation was provided in 5 trials. Both patients and investigators were blinded to treatment allocation in 3 of the 11 trials. The number of patients lost to follow-up was not reported in any of the trials.
Efficacy Outcomes

Data on the primary outcome of recurrent pulmonary embolism or death are presented in Figure 2, and summary data for individual components of this outcome are presented in Table 2. Seven of the 11 trials suggested a reduction in recurrent pulmonary embolism or death with thrombolysis compared with unfractionated heparin.45–49,53,54 The pooled estimate from all of the trials revealed a nonstatistically significant reduction in pulmonary embolism or death for thrombolysis compared with heparin (6.7% versus 9.6%; OR 0.67, 95% CI 0.40 to 1.12), with no statistical evidence of heterogeneity among the studies (P = 0.48). Similar estimates of treatment effect were obtained for pulmonary embolism (2.7% versus 4.3%; OR 0.67, 95% CI 0.33 to 1.37) and death (4.3% versus 5.9%; OR 0.70, 95% CI 0.37 to 1.30).

TABLE 1. Design of Trials Included in the Meta-Analysis

<table>
<thead>
<tr>
<th>Trial, Year</th>
<th>Eligibility</th>
<th>n</th>
<th>Thrombolysis</th>
<th>Heparin</th>
<th>Randomized Treatment</th>
<th>Subsequent Anticoagulation</th>
<th>Follow-Up*</th>
</tr>
</thead>
<tbody>
<tr>
<td>UPET trial, 1973</td>
<td>Acute PE, † symptoms ≤ 5 days</td>
<td>160</td>
<td>Urokinase 12 hours</td>
<td>Heparin</td>
<td>Thrombolysis Heparin</td>
<td>Heparin, warfarin</td>
<td>Heparin, warfarin</td>
</tr>
<tr>
<td>Tibbutt et al, 1974</td>
<td>Acute life-threatening PE †</td>
<td>30</td>
<td>Streptokinase 72 hours</td>
<td>Heparin ‡</td>
<td>Thrombolysis Heparin ‡</td>
<td>Warfarin (started at 60 hours)</td>
<td>Warfarin (started at 60 hours)</td>
</tr>
<tr>
<td>Ly et al, 1978</td>
<td>Acute major PE † symptoms &lt; 5 days</td>
<td>25§</td>
<td>Streptokinase 72 hours</td>
<td>Heparin (7 days)</td>
<td>Thrombolysis Heparin (7 days)</td>
<td>Heparin, warfarin</td>
<td>Heparin, warfarin</td>
</tr>
<tr>
<td>Dotter et al, 1979</td>
<td>Acute PE †</td>
<td>31</td>
<td>Streptokinase 18–72 hours</td>
<td>Heparin (5 days)</td>
<td>Thrombolysis Heparin (5 days)</td>
<td>Heparin, warfarin</td>
<td>Heparin, warfarin</td>
</tr>
<tr>
<td>Marini et al, 1988</td>
<td>Acute PE, symptoms ≤ 7 days</td>
<td>30</td>
<td>Urokinase, 12 hours or 3 days</td>
<td>Heparin (7 days)</td>
<td>Thrombolysis Heparin (7 days)</td>
<td>Warfarin</td>
<td>Heparin, warfarin</td>
</tr>
<tr>
<td>Levine et al, 1990</td>
<td>Acute PE, symptoms ≤ 14 days</td>
<td>58</td>
<td>tPA 2 minutes</td>
<td>Heparin</td>
<td>Thrombolysis Heparin</td>
<td>Heparin, warfarin</td>
<td>Heparin, warfarin</td>
</tr>
<tr>
<td>PIOPED, 1990</td>
<td>Acute PE, symptoms ≤ 7 days</td>
<td>13</td>
<td>tPA 40 to 90 minutes</td>
<td>Heparin</td>
<td>Thrombolysis Heparin</td>
<td>Heparin, warfarin</td>
<td>Heparin, warfarin</td>
</tr>
<tr>
<td>Dalla-Volta et al, 1992</td>
<td>Acute PE, symptoms ≤ 10 days</td>
<td>36</td>
<td>tPA 2 hours</td>
<td>Heparin</td>
<td>Thrombolysis Heparin</td>
<td>Heparin, warfarin</td>
<td>Heparin, warfarin</td>
</tr>
<tr>
<td>Goldhaber et al, 1993</td>
<td>Acute PE, symptoms ≤ 14 days</td>
<td>101</td>
<td>tPA 2 hours</td>
<td>Heparin</td>
<td>Thrombolysis Heparin</td>
<td>Heparin, warfarin</td>
<td>Heparin, warfarin</td>
</tr>
<tr>
<td>Jerjes-Sanchez et al, 1995</td>
<td>Acute massive PE, † symptoms ≤ 14 days</td>
<td>8</td>
<td>Streptokinase 2 hours</td>
<td>Heparin</td>
<td>Thrombolysis Heparin</td>
<td>Heparin, warfarin</td>
<td>Heparin, warfarin</td>
</tr>
<tr>
<td>Konstantinides et al, 2002</td>
<td>Acute PE, symptoms ≤ 4 days</td>
<td>256</td>
<td>tPA 2 hours</td>
<td>Heparin</td>
<td>Thrombolysis Heparin</td>
<td>Heparin, warfarin</td>
<td>Heparin, warfarin</td>
</tr>
</tbody>
</table>

UPET indicates Urokinase Pulmonary Embolism Trial; PE, pulmonary embolism; TCT, thrombin clotting time; tPA, tissue plasminogen activator; and PIOPED, Prospective Investigation of Pulmonary Embolism Diagnosis.

*Patients in some trials were followed up for a longer period for selected outcomes.
†Patients with major pulmonary embolism were eligible for inclusion in these trials.
‡Given as an intrapulmonary infusion.
§Therapy was not randomly allocated to 5 of the 25 patients included in the published report.

Efficacy Outcomes

Data on the primary outcome of recurrent pulmonary embolism or death are presented in Figure 2, and summary data for individual components of this outcome are presented in Table 2. Seven of the 11 trials suggested a reduction in recurrent pulmonary embolism or death with thrombolysis compared with unfractionated heparin.45–49,53,54 The pooled estimate from all of the trials revealed a nonstatistically significant reduction in pulmonary embolism or death for thrombolysis compared with heparin (6.7% versus 9.6%; OR 0.67, 95% CI 0.40 to 1.12), with no statistical evidence of heterogeneity among the studies (P = 0.48). Similar estimates of treatment effect were obtained for pulmonary embolism (2.7% versus 4.3%; OR 0.67, 95% CI 0.33 to 1.37) and death (4.3% versus 5.9%; OR 0.70, 95% CI 0.37 to 1.30).

**Figure 2.** Recurrent pulmonary embolism or death in trials comparing thrombolysis with heparin for initial treatment of acute pulmonary embolism. UPET indicates Urokinase Pulmonary Embolism Trial; PIOPED, Prospective Investigation of Pulmonary Embolism Diagnosis.
Table 4). 14,49

thrombolysis compared with heparin.45,46,48

suggested an increase in nonmajor bleeding with

the 8 trials for which nonmajor bleeding data were available

of benefit of thrombolytic therapy compared with heparin for

The currently available randomized data provide no evidence

versus a random effects model.

ingful differences between results obtained using the fixed

with a lack of major publication bias. There were no mean-

pulmonary embolism or death (Figure 3). This is consistent

of studies on either side of the summary treatment effect for

precision was relatively symmetrical, with a similar number

Deletion of individual studies did not significantly alter the

Sensitivity Analyses

Deletion of individual studies did not significantly alter the

primary outcome. A funnel plot of effect size versus study

classification was relatively symmetrical, with a similar number

of studies on either side of the summary treatment effect for

in major bleeding (9.1% versus 6.1%; OR 1.42, 95% CI 0.81 to

2.46) and a statistically significant increase in nonmajor

bleeding (22.7 versus 10.0%; OR 2.63, 95% CI 1.53 to 4.54,

number needed to harm=8).

Subgroup Analyses

Compared with heparin, thrombolytic therapy was associated

with a significant reduction in pulmonary embolism or death in

the 5 trials that included patients with major (hemodynamically

unstable) pulmonary embolism (9.4% versus 19.0%; OR 0.45,

95% CI 0.22 to 0.92, number needed to treat=10)45–48,54 but no

benefit in the 6 trials that excluded these patients (OR 1.07, 95%

CI 0.50 to 2.30; P for heterogeneity between subgroups=0.10;

Table 4).14,49–53

Safety Outcomes

Pooled data for safety outcomes are presented in Table 3.

Seven of the 11 trials suggested an increase in major bleeding

with thrombolysis compared with heparin,45–48,51–53 Seven of

the 8 trials for which nonmajor bleeding data were available

suggest an increase in nonmajor bleeding with thrombolysis

compared with heparin.45,46,48–50,52–53 The pooled data revealed a nonstatistically significant increase in

major bleeding (9.1% versus 6.1%; OR 1.42, 95% CI 0.81 to

2.46) and a statistically significant increase in nonmajor

bleeding (22.7 versus 10.0%; OR 2.63, 95% CI 1.53 to 4.54,

to death.

Registry data indicate that right ventricular dysfunction in

patients with acute pulmonary embolism is associated with an

increased risk of fatal outcomes,3,55 even in patients who are

hemodynamically stable,4 and it is therefore plausible that

these patients would derive benefit from thrombolytic therapy

compared with heparin. Unfortunately, the majority of trials

included in the present meta-analysis did not separately report

the proportion of patients with right ventricular dysfunction

without hemodynamic instability, and we were therefore

unable to further explore this question.

Previous meta-analyses have provided conflicting conclu-
sions about the benefits of thrombolytic therapy in patients

with acute pulmonary embolism. Serra-Prat et al11 and Thabut

et al12 reported no significant benefit of thrombolysis com-
pared with heparin for the initial treatment of pulmonary

embolism, whereas Agnelli et al13 reported a significant

reduction in recurrent pulmonary embolism and death. This

may be explained, at least in part, by the inclusion of patients

with clinically suspected but not objectively confirmed recur-

rent venous thromboembolism in one of these meta-analy-

ses.56 The present updated meta-analysis included only ob-

Discussion

The currently available randomized data provide no evidence

of benefit of thrombolytic therapy compared with heparin for

the initial treatment of unselected patients with acute pulmo-

nary embolism. However, subgroup analyses indicate a ben-

efit of thrombolysis compared with heparin in trials that

included patients with major pulmonary embolism but no

benefit in trials that excluded these patients. This apparent

heterogeneity of treatment effect appears to be due to an

effect of thrombolytic therapy on death, the incidence of

which was approximately 5-fold higher in heparin-treated

patients enrolled in trials that also included patients with

major pulmonary embolism. Patients at risk of dying of major

pulmonary embolism are also those most likely to achieve

benefit from thrombolytic therapy, because more rapid clot

can reverse hypotension and prevent irreversible shock that

leads to death.

TABLE 2. Recurrent Pulmonary Embolism and Death in Patients Randomized to
Thrombolysis Compared With Heparin

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Thrombolysis, n/N (%)</th>
<th>Heparin, n/N (%)</th>
<th>OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recurrent pulmonary embolism or death</td>
<td>25/374 (6.7)</td>
<td>36/374 (9.6)</td>
<td>0.67 (0.40–1.12)*</td>
</tr>
<tr>
<td>Recurrent pulmonary embolism</td>
<td>10/374 (2.7)</td>
<td>16/374 (4.3)</td>
<td>0.67 (0.33–1.37)†</td>
</tr>
<tr>
<td>Death</td>
<td>16/374 (4.3)</td>
<td>22/374 (5.9)</td>
<td>0.70 (0.37–1.30)‡</td>
</tr>
</tbody>
</table>

*Heterogeneity: P=0.48.  †Heterogeneity: P=1.00.  ‡Heterogeneity: P=0.72.

TABLE 3. Major and Nonmajor Bleeding and Intracranial Hemorrhage in Patients
Randomized to Thrombolysis Compared With Heparin

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Thrombolysis, n/N (%)</th>
<th>Heparin, n/N (%)</th>
<th>OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major bleeding</td>
<td>34/374 (9.1)</td>
<td>23/374 (6.1)</td>
<td>1.42 (0.81–2.46)*</td>
</tr>
<tr>
<td>Nonmajor bleeding</td>
<td>53/233 (22.7)</td>
<td>22/221 (10.0)</td>
<td>2.63 (1.53–4.54)†</td>
</tr>
<tr>
<td>Intracranial hemorrhage</td>
<td>2/374 (0.5)</td>
<td>1/374 (0.3)</td>
<td>1.04 (0.36–3.04)‡</td>
</tr>
</tbody>
</table>

*Heterogeneity: P=0.92.  †Heterogeneity: P=0.53.  ‡Heterogeneity: P=1.00.
Objective: To directly compare thrombolytic therapy with heparin in patients with recurrent pulmonary embolism or death.

Methods: A comprehensive review of current evidence was performed, and the totality of the randomized evidence was determined by including all relevant properly randomized trials. Unpublished studies, and by utilizing explicit methodology for study selection, data extraction, and data analysis. Furthermore, we considered the totality of the randomized evidence by including all relevant properly randomized trials.

Conclusions: The currently available data provide no evidence for a benefit of thrombolytic therapy compared with heparin for the initial treatment of unselected patients with acute pulmonary embolism. However, a clear benefit is suggested among those at highest risk of recurrence or death, in particular, patients with major pulmonary embolus who present with hemodynamic instability. Further evaluation of the efficacy and safety of thrombolytic therapy for the treatment of high-risk patients with acute pulmonary embolism appears warranted.

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References
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