DDAVP Shortens the Prolonged Bleeding Times of Patients With Severe von Willebrand Disease Treated With Cryoprecipitate. Evidence for a Mechanism of Action Independent of Released von Willebrand Factor

By Marco Cattaneo, Marco Moia, Patrizia Della Valle, Paola Castellana, and Pier Mannuccio Mannucci

After infusion of cryoprecipitate, the very prolonged bleeding time of patients with severe von Willebrand disease (vWD) is shortened but not always normalized in spite of normalization of plasma von Willebrand factor (vWF) levels. Therefore treatments that further improve primary hemostasis in severe vWD patients are needed. Since DDAVP shortens the bleeding time in a variety of bleeding disorders, we investigated in a double-blind, placebo-controlled crossover study the effects of the intravenous (IV) infusion of DDAVP (0.3 μg/kg) on the bleeding times of 10 patients with severe vWD treated with cryoprecipitate. Their very prolonged bleeding times (>30 minutes), partially corrected by the infusion of cryoprecipitate (14 ± 2 minutes, mean ± SEM), were further shortened by the administration of DDAVP (9 ± 2 minutes, P < .01) but not of saline (15 ± 3 minutes, ns). Plasma vWF levels, raised from unmeasurable to normal values by cryoprecipitate, were not changed after DDAVP or saline. The defective deposition of platelets from eight patients onto human umbilical artery subendothelium was increased but not normalized by cryoprecipitate and was not significantly affected by DDAVP or saline. Therefore the infusion of DDAVP after cryoprecipitate may be of clinical benefit for management of bleeding episodes in severe vWD patients. Since severe vWD patients do not have releasable tissue stores of vWF, DDAVP must shorten their prolonged bleeding times independently of released vWF.

This double-blind, placebo-controlled crossover study was performed to see whether DDAVP shortens the bleeding time of severe vWD patients treated with cryoprecipitate. Since severe vWD patients do not have releasable vWF in tissue stores, this study provided an opportunity to see whether or not DDAVP can shorten the bleeding time independently of released vWF.

MATERIALS AND METHODS

Patients. Ten multitransfused patients with severe vWD were studied. They had unmeasurable levels of vWF:antigen (vWF:Ag) and vWF:ristocetin cofactor (vWF:RistCof) in both plasma and platelets and have been previously described.23 They needed cryoprecipitate infusions for treatment of joint or muscle hemorrhages. All patients gave informed consent to the study and to further treatment with DDAVP or saline.

Treatment schedule. After an attempt to shorten their very prolonged bleeding times (>30 minutes) with infusion of wet cryoprecipitate (half a bag/kg) made by our hospital blood bank, severe vWD patients were randomly and blindly assigned to treatment with 0.3 μg/kg DDAVP or saline, infused intravenously (IV) over 30 minutes. DDAVP or saline infusions were started 30 minutes after administration of DDAVP or saline. Therefore the infusion of cryoprecipitate to allow measurements of postcryoprecipitate bleeding times. Treatments with DDAVP or saline were crossed over after at least 15 days on occasion of new bleeding episodes needing cryoprecipitate infusion. Bleeding times were obtained, and venous blood was collected in trisodium citrate, saline were crossed over after at least 15 days on occasion of new bleeding episodes needing cryoprecipitate infusion. Bleeding times were obtained, and venous blood was collected in trisodium citrate, 12.9 mmol/L (for plasma vWF measurements) and 11 mmol/L (for studies of platelet deposition onto umbilical artery subendothelium) immediately before and after infusion of cryoprecipitate and after the infusion of DDAVP or saline.

Bleeding time. Bleeding times were measured on the forearm with a template method (Symplate II, General Diagnostics, Milan, Italy) by an expert operator. Results were expressed as the average bleeding time from the two vertical incisions. Since DDAVP treatment can sometimes be detected from the mild facial flushing caused by the drug, to avoid biases in the measurement of the bleeding time, the operator was kept unaware of either the ongoing treatment or the design and purpose of the study. (She did not know that DDAVP was the drug being tested, nor did she know the expected effects of the test drug on the bleeding time.) Measurements of plasma vWF:RistCof, and vWF multimeric analysis were carried out as described18 using an electroimmunoassay assay (vWF:Ag), an aggregometric assay with formalin-fixed platelets, and an immunoblotting assay with platelets.

From A. Bianchi Bonomi Hemophilia and Thrombosis Center and Institute of Internal Medicine, Maggiore Hospital and University of Milan, and Institute of Human Anatomy, University of Milan, Italy.

Submitted March 21, 1989; accepted June 16, 1989.

Supported in part by National Institutes of Health grant HL411336.

Address reprint requests to Dr Marco Cattaneo, Hemophilia and Thrombosis Center, Via Pace 9, 20122 Milano, Italy.

The publication costs of this article were defrayed in part by page charge payment. This article must therefore be hereby marked “advertisement” in accordance with 18 U.S.C. section 1734 solely to indicate this fact.

© 1989 by Grune & Stratton, Inc.
**DDAVP AND CRYO IN SEVERE VON WILLEBRAND**

![Fig 1](image)

**Changes in bleeding times in 10 patients with severe vWD treated with infusion of cryoprecipitate (half a bag/kg), followed by the infusion of DDAVP (0.3 μg/kg, panel A) or saline (panel B). Different symbols have been used to indicate each patient. The dashed horizontal line indicates the upper limit of the normal range for the bleeding time (7 minutes).**

Hypo- and hyper-platelets (vWF:RiCof), and sodium dodecyl sulfate (SDS)-agarose gel electrophoresis (vWF multimers). Platelet deposition onto human umbilical artery subendothelium was measured as previously described. Briefly, de-endothelialized human umbilical arteries were perfused for 5 minutes with citrated blood from 8 of the 10 patients with severe vWD in an annular perfusion chamber at 37°C. Since defective platelet deposition onto artery subendothelium in vWD patients is pronounced only at high shear rates (>1,000 sec⁻¹), perfusion studies were performed at a constant shear rate of 1,800 sec⁻¹. After perfusion, vessel segments were fixed, embedded, and sectioned. Platelet deposition onto the subendothelium was quantified morphometrically and expressed as platelet coverage and platelet thrombus formation. Platelet coverage was the percentage of subendothelial surface covered by both contact and spread platelets. Thrombus formation was the percentage of subendothelial surface covered by thrombi more than 5 μm in height.

The Student’s t test for paired data was used to analyze the data.

**RESULTS**

**Bleeding time.** The very prolonged bleeding times of the 10 severe vWD patients (>30 minutes) were shortened to the same degree in both the series of treatments by the infusion of cryoprecipitate (Fig 1 and Table 1) but was normalized in only 1 of the 10 patients (Fig 1a). The prolonged bleeding times of nine patients were further shortened by the infusion of DDAVP and became normal in five additional patients.

**Table 1. Effects of the Infusion of Cryoprecipitate, Followed by DDAVP or Saline on the Bleeding Times and Plasma vWF Levels of 10 Patients With Severe vWD**

<table>
<thead>
<tr>
<th></th>
<th>Normal Range</th>
<th>After Cryoprecipitate</th>
<th>After DDAVP</th>
<th>After Cryoprecipitate</th>
<th>After Saline</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bleeding time (min)</strong></td>
<td>&lt;7</td>
<td>14 ± 2</td>
<td>9 ± 2*</td>
<td>15 ± 3</td>
<td>15 ± 3</td>
</tr>
<tr>
<td>vWF-Ag (U/dL)</td>
<td>50-150</td>
<td>75 ± 7</td>
<td>69 ± 6</td>
<td>92 ± 9</td>
<td>83 ± 10</td>
</tr>
<tr>
<td>vWF-RiCof (U/dL)</td>
<td>50-150</td>
<td>64 ± 7</td>
<td>64 ± 7</td>
<td>76 ± 8</td>
<td>63 ± 7</td>
</tr>
</tbody>
</table>

Mean is ± SEM.

Bleeding times were >30 minutes, vWF-Ag and vWF-RiCof were unmeasurable (<1 U/dL and <6.5 U/dL, respectively) before the infusion of cryoprecipitate.

*Significantly different from after cryoprecipitate (P < .01), t test for paired data.
Table 2. Deposition of Platelets From Eight Patients With Severe vWD Treated With Cryoprecipitate, Followed by DDAVP or Saline Infusion, and Six Normal Subjects Onto Human Umbilical Artery Subendothelium

<table>
<thead>
<tr>
<th>Severe vWD Patients</th>
<th>Normal Subjects</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline</td>
</tr>
<tr>
<td>Coverage (%)</td>
<td>42 ± 7</td>
</tr>
<tr>
<td>Thrombi (%)</td>
<td>6.8 ± 2</td>
</tr>
</tbody>
</table>

Mean is ± SEM.
*Significantly different from baseline values (P < .01), t test for paired data.

Discussion

This double-blind, placebo-controlled crossover study shows that DDAVP further shortened the prolonged bleeding times of severe vWD patients after partial correction by the infusion of cryoprecipitate. Soft tissue and postsurgical bleeding can be effectively controlled in vWD patients by the infusion of vWF concentrates and by the associated normalization of the factor VIII:C plasma levels independently of vWF released from tissue stores. However, spontaneous mucosal bleedings cannot be stopped unless the Ivy bleeding time is shortened to normal values. DDAVP from tissue stores might enhance platelet adhesion onto subendothelium and thereby potentiate primary hemostasis. However, mechanisms independent of released vWF have also been advocated. Barnhart et al.8,18 for instance, showed that DDAVP in vitro enhances platelet adhesion onto the subendothelium through a mechanism not involving the release of vWF. Mechanisms independent of released vWF are difficult to explore in vivo because any subject with measurable vWF plasma levels usually releases vWF from tissue stores when infused with DDAVP. We thought that severe vWD patients with prolonged bleeding times after treatment with cryoprecipitate and DDAVP shortens the prolonged bleeding time independently of vWF released from tissue stores.

In earlier studies we showed that DDAVP does not shorten the bleeding times of severe vWD patients, in apparent contrast with the results of the present study. However, the effect of DDAVP might have been missed in these patients not treated with cryoprecipitate because their bleeding times were not measured beyond 30 minutes and were recorded only as longer than 30 minutes. The further shortening of the bleeding time induced by DDAVP in the present study was not great, being of the same magnitude as that attained in previous studies of patients with prolonged bleeding times and normal or even increased plasma vWF levels (see Table 1 of reference 6 for review).

Being independent of released vWF, the mechanism by which DDAVP shortens the prolonged bleeding time is unknown. Although our ex vivo study showed a trend toward an increase in platelet deposition onto human umbilical artery subendothelium after infusion of severe vWD patients with DDAVP, the observed increase was not statistically significant. The difference between our results and those of Barnhart et al. who found that DDAVP increases platelet deposition onto vascular subendothelium in vitro, may be explained by the fact that the plasma drug concentrations that are attainable in vivo after the IV infusion of 0.3 µg/kg DDAVP (about 1 ng/mL) are lower than those used by Barnhart et al (7 ng/mL) in their in vitro study.18
REFERENCES

DDAVP shortens the prolonged bleeding times of patients with severe von Willebrand disease treated with cryoprecipitate. Evidence for a mechanism of action independent of released von Willebrand factor

M Cattaneo, M Moia, P Delle Valle, P Castellana and PM Mannucci