



Is Elevated Red Blood Cell Distribution Width Value a Prognostic Marker in Sepsis Patients?

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Authors' contributions

This work was carried out in collaboration between both authors. Author SS designed the study, performed the statistical analysis, wrote the protocol, and wrote the first draft of the manuscript. Author AT managed the analyses of the study and managed the literature searches. Both authors read and approved the final manuscript.

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ABSTRACT

Sepsis and its complications are a common cause of infectious disease and death in worldwide. But the infection can be challenges to confirm and there is gold standard methods to confirm it. Red blood cell distribution width (RDW) value frequently measured at every complete blood count. In sepsis the RDW morphology changes are believed to be mainly related to prognosis. RDW has also been studied as an independent variable in different predictive score. We systematically review the articles can RDW be used as prognostic marker in patient with sepsis.

Keywords: Sepsis; RDW; blood cell.

1. INTRODUCTION

Sepsis is a dysregulated host response to infection resulting in potential life-threatening organ dysfunction. Diagnosis of the infections,

there is no existing gold standard method. Delays in the empirical treatment of sepsis and bacteremia increase mortality, length of hospitalization, and cost. Increase in (RDW), a simple and routine investigation, can

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be used as a prognostic marker in sepsis patients.

2. RED BLOOD CELL DISTRIBUTION WIDTH

The red blood cell distribution width is an indicator of changes in RBC size or RBC volume. Most automated instruments will quantitatively evaluate the red blood cell volume changes indicated by the RDW, which resembles to the microscopic examination of the degree of heterogeneous effects. The RDW derived from the pulse height analysis can be stated as the standard deviation of fl (SD), or as a percentage of the coefficient of variation (CV) of the red blood cell volume measurement.

3. POSSIBLE PATHOPHYSIOLOGICAL MECHANISMS EXPLAINING RDW CHANGES IN SEPTIC PATIENTS

Rheological changes of red blood cells can change the RDW of patients with sepsis [1]. The mechanism of shape (spherical), volume, and deformability of red blood cells is still not fully understood [1], but several mechanisms have been proposed in patients with sepsis: the redistribution of phosphatidylserine on the lobules of the outer membrane of red blood cells [2,3], altered acidic membrane content of salivary red blood cells [4,5], with 3 protein phosphorylation [6], redox imbalance [7–9], calcium [10], 2,3-diphosphoglycerate [11] and adenosine triphosphate [12] homeostasis changes and nitric oxide pathway modulation [13,14]. In addition, the inflammatory response indirectly regulates hematopoietic function through abnormal iron metabolism, increased hemolysis, and reduced red blood cell lifespan, which in turn leads to increased release of immature forms into the blood [7].

4. RDW AND PROGNOSIS IN SEPTIC PATIENTS

Many studies on RDW and prognosis are for all Intensive Care Unit (ICU) admitted patients [15,16], with sepsis. Only a less studies have concentrated on how RDW predicts the mortality of patients with sepsis [17–20]. Some authors have studied in-hospital mortality [17,21], while the goals of other studies are short-term [18,22] and long-term prognosis [23]. A retrospective study [17] included 279 septic shock patients and

described "RDW is a powerful predictor of hospital mortality." The subjects were divided into five equal parts (19.4%) according to the RDW value on the first day of septic shock. RDW is significantly related to mortality within the RDW range, odds ratio [OR] = 4.6 (95% confidence interval [CI], 1.0-23.4; p = 0.06), OR = 8.0 (95% CI, 1.5-41.6; p 19.4%, respectively.

The mortality during these time intervals was studied relative to subjects with RDW <13.5%. The RDW value at the time of ICU admission and its relationship with mortality in the intensive care unit was also studied in patients with community-acquired intra-abdominal sepsis [24]. Among these patients, RDW has a good distinguishing ability in predicting ICU mortality, and the area under the curve (AUC) estimated by receiver operating characteristic (ROC) analysis is 0.867 (95% CI, 0.791–0.942). In addition, some authors focused on elderly patients with sepsis and septic shock [21,25]. Both studies found a significant correlation between the increase in RDW and ICU mortality in elderly patients [21] and the 30-day mortality [26]. The average age of the study by Wang et al. [21] is 81.5±8.3, and the average age by Kim et al. [25] is 78 years. The potential problems of these studies are first related to the type-retrospective, but the second most important is the study population.

Regardless of sepsis and septic shock, are older people more likely to have RDW changes. As mentioned above, many diseases and conditions may change RDW, and elderly patients should be considered, because elderly patients often do not have one disease, but many diseases, and most of them may be in advanced stages. Therefore, this concept of fragility should be added to any changes in RDW [20]. It is hoped that after considering all these risk factors in a multivariate analysis, changes in RDW in elderly patients with sepsis will be significantly correlated with mortality, while RDW will still be associated with ICU mortality. After multivariate adjustment, Wang et al. [21] found that RDW was significantly related to ICU mortality (hazard ratio [HR] = 1.18; 95% CI, 1.03-1.35; p = 0.019). Jo et al. [22] retrospectively studied 566 patients with severe sepsis and septic shock (as defined by the old definition of sepsis). The RDW value is divided into three quantiles (<14%, 14.1% to 15.7%, > 15.8%), and the mortality rate is studied range by range. The authors found that RDW was elevated in non-survivors and was significantly associated with 28-day mortality.

COX regression analysis showed that RDW is an independent determinant of 28-day mortality: RDW > 15.8% (HR = 2.57; 95% CI, 1.53-4.34; p 15.5%). The 28-day and 90-day patients are 44.9% Kim et al. [27] Studied the mortality rate, collected the RDW value on admission, and measured its dynamics in the next 72 hours (Δ RDW72hr-adm), patients with an elevated baseline RDW value and patients with an elevated RDW > 0.2% the first 72 hours (Δ RDW72hr-adm > 0.2%) presents the highest risk of mortality at 28 and 90 days. Finally, Han et al. [23] only studied the long-term prognosis. This retrospective observational study used a huge critical care database (Intensive Care Medical Information Center), which included a total of 4264 patients with sepsis, and studied the relationship between their 4-year mortality rate and the baseline RDW value. In the multivariate COX analysis, RDW was individually related with all-cause mortality and had a moderate discriminating ability. ROC analysis estimated its AUC to be 0.64 (95% CI, 0.63-0.66).

In a recent study done by Foy et al. [28] studied on a total of 1641 patients showed elevated RDW (>14.5 %) value show increases mortality in-hospital who suffered from SARS-COV-2 infections.

5. CONCLUSION

By this review, it is understood that RDW value which is a part of an automated CBC which is a done routinely, which is cheap, easily available parameter on admission can be used as a prognostic marker in patients in sepsis. Furthermore studies are needed to confirm these data.

CONSENT

It is not applicable.

ETHICAL APPROVAL

It is not applicable.

COMPETING INTERESTS

Authors have declared that no competing interests exist.

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