An increase in mean platelet volume (MPV) as a predictor of mortality in children with sepsis

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ABSTRACT

Sepsis is associated with increased morbidity and mortality in children worldwide, mainly in developing countries. This fatal risk emphasizes the importance of finding accessible and inexpensive parameters to be used as predictors for mortality in children with sepsis. The aim of this study was to determine the role of increased mean platelet volume (MPV) as a predictor for mortality in children with sepsis. A case control study was applied using medical records of all in-patients aged 1 mo -18 y diagnosed with sepsis at Dr. Sardjito General Hospital, Yogyakarta from January 2015-December 2016. Bivariate and multivariate analyses by Chi-square and logistic regression to evaluate the correlations between increased MPV within the first 24-72 h (ΔMPV>0) and mortality were applied. Eighty-one eligible subjects met the inclusion/exclusion criteria with the mortality was 52%. Chi-square analysis showed significant correlations between increased MPV and mortality (p=0.005). Multivariate analysis showed increased MPV within the first 24-72 h after sepsis diagnosis as a predictor for mortality after controlling for sex and AKI (adjusted OR 3.851; 95% CI:1.354-10.948; p= 0.011). In conclusion, an increase in MPV within the first 24-72 h after diagnosed is an independent predictor for mortality in children with sepsis.

ABSTRACT

INTRODUCTION

Sepsis is a life-threatening organ dysfunction caused by a dysregulated immune system due to infection. Sepsis affects millions of people worldwide each year, and is associated with high morbidity, mortality, and health-maintenance costs. Sepsis is also a major cause of infant and child mortality worldwide. The incidence of sepsis increased in recent years, especially in developing countries. Based on epidemiological studies in the United States, the incidence of severe sepsis involved 0.56 cases per 1000 population per year, with a mortality reaching 10.3% (more than 4383 deaths per year). The incidence of sepsis in the Pediatric Intensive Care Unit (PICU) Dr. Cipto Mangunkusumo Hospital (RSCM), Jakarta was 19.3% with a mortality rate 10%. High mortality rate encourages applied research to discover easily accessible and inexpensive methods that can be widely used to know the severity of sepsis when diagnosed so an optimal management approach can be developed to reduce mortality.

Mean platelet volume (MPV) is a simple and accurate marker of functional status and size of the platelets. Some research hypothesized that cytokines such as interleukin 3 (IL-3) and IL-6 in sepsis patients will affect megakaryocytes ploidy that leads to the production of more reactive and larger platelets, so MPV will increase. In healthy populations, MPV has an inverse correlation with the number of platelets, but biological effects, clinical significance, and its association with sepsis is still not clearly understood.

Previous study explains that the measurement of the MPV can be used as predictors of mortality in patients with sepsis and critical illness. Study on the role of MPV as a predictor of mortality in children with sepsis is still rarely conducted. The procedure of MPV measurement is very simple and does not require high cost. This study aimed to determine the MPV role as a predictor of mortality in children with sepsis.

MATERIALS AND METHODS

Design of study

We conducted a prognostic study with matched case control design at Dr. Sardjito General Hospital, Yogyakarta by reviewing medical records. Subjects were patients aged 1 mo-18 y who were diagnosed with sepsis based on Indonesian Pediatric Society 2016 criteria and were hospitalized in the Pediatric Intensive Care Unit (PICU) since January 2015 to December 2016, with performed blood cultures and MPV measurement.

Protocol of study

Mean platelet volume value came as part of complete blood count measurement using a quantitative automated hematology analyzer which analyzed at the clinical pathology laboratory of Dr. Sardjito General Hospital. Mean platelet volume measurement was taken at diagnosis and within 24-72 h thereafter. Mean platelet volume values were recorded from the medical record. Subjects were excluded if there was comorbidity such as hematologic abnormalities (leukemia, immune thrombocytopenic purpura, essential thrombocytosis, abnormal platelet
function, aplastic anaemia), asplenia, chronic diseases, organ transplantation, malignancies, congenital abnormalities, immunosuppressive drugs or discharge against medical advice.

The case group was children based on inclusion and exclusion criteria who died during hospitalization, and the control group was children who were survived, match by age. The data taken including age, gender, nutritional status, number of leukocytes, MPV value at the time diagnosed as sepsis (MPV<sub>1</sub>), MPV values within 24-72 h after diagnosed (MPV<sub>2</sub>), changes in the value MPV within 24-72 h after diagnosed (ΔMPV), the number of platelets, acute kidney injury (AKI), disseminated intravascular coagulation (DIC), septic shock and the outcomes (dead or alive). Mean platelet volume values taken were the result of blood sample analysis in the clinical pathology laboratory that were written in medical records or tracked from clinical laboratory installation. If there were more than one examination within the time range (24-72 h), the MPV value that was recorded is the latest MPV. Mean platelet volume is considered high when MPV value > 10.4 fl, and increased when ΔMPV>0 (MPV<sub>2</sub>-MPV<sub>1</sub> >0). Other data were taken from examination performed within 72 h after sepsis diagnosis.

**Statistical analysis**

Descriptive analysis was conducted to describe the basic characteristics of the subjects and the data was displayed in the form of proportions. Bivariate analysis by Chi-square test was conducted to determine any correlation between an increase in MPV (ΔMPV>0), thrombocytopenia, leukopenia, age, gender, AKI, DIC and septic shock with mortality. Multivariate analysis by logistic regression was performed for an increase in MPV (ΔMPV>0) and confounders with p value < 0.25 to determine the adjusted OR. This study was approved from the Medical Research Ethics Committee of the Faculty of Medicine, Public Health and Nursing, Universitas Gadjah Mada/Dr. Sardjito General Hospital, Yogyakarta (ref. number KE/FK/0546/EC/2017).

**RESULTS**

Within 2 years (January 1<sup>st</sup>, 2015 - December 31<sup>th</sup>, 2016) there were 81 subjects who met the study criteria. Subjects’ characteristics are shown in Table 1. Median of age was 25-month (1-205-month), with higher proportion of patients younger than 5 years old (66.7% versus 33.3%). Diseases related to the occurrence of sepsis in this study include pneumonia (28.4%), dengue shock syndrome (24.7%), intracranial infection (19.8%), surgery (9.9%), gastrointestinal infections (4.9%), skin infections (3.7%), and typhoid fever (1.2%). Pneumonia is most prevalent in the case group (43.9%), while dengue shock syndrome is most prevalent in the control group (30.0%). Positive culture was found in 65.4% of the subjects. The most common pathogens are *Streptococcus viridans* (17.3%), *Klebsiella pneumoniae* (11.8%), *Candida sp.* (10.9%), *Acinetobacter baumanii* (9.1%), *E. coli* (9.1%), *Enterobacter cloacae* (5.5%), and *Pseudomonas aeruginosa* (5.5%).
TABLE 1. Basic characteristics of subjects

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Died (n = 41)</th>
<th>Alive (n = 40)</th>
<th>Total (n = 81)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;5 years</td>
<td>27 (65.9)</td>
<td>27 (67.5)</td>
<td>54 (66.7)</td>
</tr>
<tr>
<td>≥ 5 years</td>
<td>14 (34.1)</td>
<td>13 (32.5)</td>
<td>27 (33.3)</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boys</td>
<td>24 (58.5)</td>
<td>34 (85.0)</td>
<td>58 (71.6)</td>
</tr>
<tr>
<td>Girls</td>
<td>17 (41.5)</td>
<td>6 (15.0)</td>
<td>23 (28.4)</td>
</tr>
<tr>
<td><strong>Underlying diseases</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical cases</td>
<td>1 (2.4)</td>
<td>7 (17.5)</td>
<td>8 (9.9)</td>
</tr>
<tr>
<td>Non-surgical cases</td>
<td>40 (97.6)</td>
<td>33 (82.5)</td>
<td>73 (90.1)</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>18 (43.9)</td>
<td>5 (12.5)</td>
<td>23 (28.4)</td>
</tr>
<tr>
<td>Dengue shock syndrome</td>
<td>8 (19.5)</td>
<td>12 (30.0)</td>
<td>20 (24.7)</td>
</tr>
<tr>
<td>Intracranial infection</td>
<td>8 (19.5)</td>
<td>8 (20.0)</td>
<td>16 (19.8)</td>
</tr>
<tr>
<td>Gastrointestinal infections</td>
<td>1 (2.4)</td>
<td>3 (7.5)</td>
<td>4 (4.9)</td>
</tr>
<tr>
<td>Skin infections (burns, cellulitis, abscesses)</td>
<td>1 (2.4)</td>
<td>2 (5.0)</td>
<td>3 (3.7)</td>
</tr>
<tr>
<td>Typhoid fever</td>
<td>0 (0.0)</td>
<td>1 (2.5)</td>
<td>1 (1.2)</td>
</tr>
<tr>
<td>&gt; 1 source of infection</td>
<td>4 (9.8)</td>
<td>2 (5.0)</td>
<td>6 (7.4)</td>
</tr>
<tr>
<td>Wasted or severely wasted</td>
<td>13 (31.7)</td>
<td>9 (22.5)</td>
<td>22 (27.2)</td>
</tr>
<tr>
<td>Positive culture</td>
<td>20 (48.8)</td>
<td>33 (82.5)</td>
<td>53 (65.4)</td>
</tr>
<tr>
<td>Blood</td>
<td>0 (0.0)</td>
<td>5 (12.5)</td>
<td>5 (6.2)</td>
</tr>
<tr>
<td>Feces</td>
<td>1 (2.4)</td>
<td>0 (0.0)</td>
<td>1 (1.2)</td>
</tr>
<tr>
<td>Respiratory tract</td>
<td>7 (17.1)</td>
<td>10 (25.0)</td>
<td>17 (21.0)</td>
</tr>
<tr>
<td>Others</td>
<td>1 (2.4)</td>
<td>1 (2.5)</td>
<td>2 (2.5)</td>
</tr>
<tr>
<td>&gt; One kind of sample</td>
<td>11 (26.8)</td>
<td>17 (42.5)</td>
<td>28 (34.6)</td>
</tr>
</tbody>
</table>

This study showed that MPV$_1$ and MPV$_2$ values had no effect on mortality, while an increase in MPV ($\Delta$MPV$> 0$) did have a significant effect on mortality ($p = 0.005$) (TABLE 2). The results of the bivariate analysis of other variables also shown in TABLE 2. Thereafter, multivariate analysis by logistic regression was performed for an increase in MPV ($\Delta$MPV$> 0$) and confounders with p value < 0.25 to determine the adjusted OR. Confounders which included was female gender, leukopenia, AKI, DIC, and septic shock. We obtained adjusted OR of $\Delta$MPV$> 0$ based on reference model (model 1) was 4.144 (95% CI 1.328 to 12.933; $p = 0.014$) (Table 3). After analyzed for the best model that would be used based on its validity and precision, we obtained final adjusted OR of $\Delta$MPV$> 0$ was 3.851 (95% CI 1.354 to 10.948; $p = 0.011$) (TABLE 3).
TABLE 2. Result of bivariate analysis on the factors that affect mortality in sepsis

<table>
<thead>
<tr>
<th>Variables</th>
<th>Died (n = 41)</th>
<th>Alive (n = 40)</th>
<th>p*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n (%)</td>
<td>n (%)</td>
<td></td>
</tr>
<tr>
<td>MPV&lt;sub&gt;1&lt;/sub&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;10.4 fl</td>
<td>10 (24.4)</td>
<td>15 (37.5)</td>
<td>0.202</td>
</tr>
<tr>
<td>≤10.4 fl</td>
<td>31 (75.6)</td>
<td>25 (62.5)</td>
<td></td>
</tr>
<tr>
<td>MPV&lt;sub&gt;2&lt;/sub&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;10.4 fl</td>
<td>19 (46.3)</td>
<td>11 (27.5)</td>
<td>0.079</td>
</tr>
<tr>
<td>≤10.4 fl</td>
<td>22 (53.7)</td>
<td>29 (72.5)</td>
<td>0.005</td>
</tr>
<tr>
<td>ΔMPV increased</td>
<td>28 (68.3)</td>
<td>15 (37.5)</td>
<td>0.875</td>
</tr>
<tr>
<td>Aged &lt;5 years</td>
<td>27 (65.8)</td>
<td>27 (67.5)</td>
<td>0.008</td>
</tr>
<tr>
<td>Female gender</td>
<td>17 (41.5)</td>
<td>6 (15.0)</td>
<td>0.118</td>
</tr>
<tr>
<td>Leukopenia</td>
<td>4 (9.7)</td>
<td>9 (22.5)</td>
<td>0.745</td>
</tr>
<tr>
<td>Thrombocytopenia</td>
<td>18 (43.9)</td>
<td>19 (47.5)</td>
<td>0.352</td>
</tr>
<tr>
<td>Wasted or severely wasted</td>
<td>13 (31.7)</td>
<td>9 (22.5)</td>
<td>0.000</td>
</tr>
<tr>
<td>Acute kidney injury (AKI)</td>
<td>21 (51.2)</td>
<td>5 (12.5)</td>
<td>0.002</td>
</tr>
<tr>
<td>Disseminated intravascular coagulation (DIC)</td>
<td>24 (58.5)</td>
<td>10 (25.0)</td>
<td>0.005</td>
</tr>
<tr>
<td>Septic shock</td>
<td>28 (68.3)</td>
<td>18 (45.0)</td>
<td>0.034</td>
</tr>
</tbody>
</table>

TABLE 3. Validity and precision of potential models based on multivariate analysis by logistic regression

<table>
<thead>
<tr>
<th>Model</th>
<th>OR</th>
<th>95%CI</th>
<th>OR changes from reference model (%)</th>
<th>Precision</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model 1 or reference model (controlling for gender, leucopenia, AKI, DIC and septic shock)</td>
<td>4.144</td>
<td>1.328-12.933</td>
<td>-</td>
<td>11.605</td>
<td>0.014</td>
</tr>
<tr>
<td>Model 2 (controlling for gender, AKI, DIC and septic shock)</td>
<td>3.926</td>
<td>1.275-12.089</td>
<td>5.3</td>
<td>10.814</td>
<td>0.017</td>
</tr>
<tr>
<td>Model 3 (controlling for AKI, DIC and septic shock)</td>
<td>3.609</td>
<td>1.220-10.677</td>
<td>12.9</td>
<td>9.457</td>
<td>0.020</td>
</tr>
<tr>
<td>Model 4 (controlling for gender, AKI and septic shock)</td>
<td>4.413</td>
<td>1.477-13.190</td>
<td>6.5</td>
<td>11.713</td>
<td>0.008</td>
</tr>
<tr>
<td>Model 5 or final model (controlling for gender and AKI)</td>
<td>3.851</td>
<td>1.354-10.948</td>
<td>7.1</td>
<td>9.594</td>
<td>0.011</td>
</tr>
<tr>
<td>Model 6 (controlling for gender)</td>
<td>3.859</td>
<td>1.458-10.211</td>
<td>6.9</td>
<td>8.753</td>
<td>0.007</td>
</tr>
<tr>
<td>Model 7 (Unadjusted)</td>
<td>3.590</td>
<td>1.434-8.988</td>
<td>13.4</td>
<td>7.554</td>
<td>0.006</td>
</tr>
</tbody>
</table>

DISCUSSION

In the present study, we have evaluated the MPV role as a predictor of mortality in children with sepsis. The bivariate analysis showed there was no correlation between MPV<sub>1</sub>, MPV<sub>2</sub> and mortality in children with sepsis (p = 0.202 and p = 0.079 respectively), while an increase in MPV within 24-72 h after diagnosed as sepsis (ΔMPV > 0) is associated with higher mortality (p = 0.005). After conducting multivariate analysis, we obtained adjusted OR for ΔMPV>0 was 3.851 (95% CI 1.354 to 10.948; p = 0.011).

Sepsis causes immune dysregulation resulting in the release of various pro-inflammatory cytokines that affect megakaryocytes. Sepsis also
leads to increase growth factors such as thrombopoietin which regulates
megakaryocytes proliferation and differentiation.\textsuperscript{16} As the result, the
young platelets which are larger and more active are released.\textsuperscript{17,18} These large
platelets are characterized by an increase in MPV. Furthermore, an increase in
MPV also indicates that the platelets are more active functionally, metabolically
and enzymatically than the small ones. This difference is due to an increase in
the content of alpha granules and dense granules, thromboxane A2 intracellular,
and pro-coagulation surface proteins such as P-selectin and glycoprotein IIa/
IIla.\textsuperscript{10}

The results of this study are similar to several previous study, which showed
that MPV increased significantly within 72 h after admission in the group of
deceased patients caused by sepsis (p = 0.001).\textsuperscript{10} Similarly, the study by Erdogan
concluded that there was no correlation between mortality and MPV value
obtained at admission and 48 h later in critically ill children (p = 0.480 and p =
0.213 respectively), but an increase in MPV within 48 h after treatment in the
pediatric intensive care unit is associated with higher mortality (p <0.001).\textsuperscript{19}
Therefore, serial MPV measurements may help to predict poor outcome in
pediatric patients with sepsis to optimize the treatment and reduce mortality.

Another factor associated with mortality in children with sepsis is the presence of AKI (OR 6.129; 95%CI 1.844
to 20.369; p = 0.003). This is consistent with a previous study that concluded AKI
as a risk factor of mortality in children with severe sepsis (OR 2.5; 95%CI 1.5
to 4.2; p = 0.001).\textsuperscript{20} Septic patients with
AKI are associated with poorer outcome
due to organ dysfunction, so that the
risk of death is greater. Meanwhile, the
influence of gender on mortality was not
statistically significant (OR 3.157; 95%CI
0.944 to 10.562; p = 0.062).

The mortality rate of sepsis based
on this study is 50.6%. This result is
consistent with a previous study that
showed the mortality rate in children
with sepsis who were hospitalized
at PICU Dr. Sardjito General Hospital
from July to November 2012 was 52%.\textsuperscript{21}
The diagnosis of sepsis is confirmed by
PELOD-2 score with cut-off ≥11 which
is associated with an increase in mortality
≥ 30.5%.\textsuperscript{1}

Most subjects were aged <5 years
(66.7%) with the youngest only 1 month
old. Research determined the maturity
of immune system depends on the
age, so the younger patients had lower
maturity to eliminate pathogens thereby
increasing the risk of sepsis.\textsuperscript{22} In this
study, there was no age difference in the
case group or control group. This finding
is similar to Saraswati’s study which
reported that the ages <5 y.o. are not
proved to be a risk factor for mortality
in children with sepsis.\textsuperscript{4} However, the
proportion of children aged 1-12 mo in
case group was higher than the control
group, although the finding was not
statistically significant (46.3% versus
35.0%, p = 0.299).

We found male predominance with
ratio of 2.5:1. However, the proportion
of female subjects in the case group was
higher than the control group (41.5% vs.
15.0%). This finding is consistent with
the results of Pietropaoli’s study that
concluded although the incidence of
sepsis was greater in male patients, still
females with severe sepsis/septic shock
have higher mortality risk (OR 1.11;
95%CI 1.04 to 1.19; p = 0.002).\textsuperscript{23} Positive
culture found in this study was similar
to a previous study that found etiological
pathogens in as many as 40-60% cases.\textsuperscript{24}

This study has several limitations.
The retrospective design by reviewing
medical records gave us difficulties to
obtain complete information. Mean
platelet volume data also were obtained
retrospectively, so the timing of blood
sampling was different in all subjects and
we could not control the time interval
between blood sampling and laboratory processing. One previous study showed that the duration of blood sample in ethylenediaminetetraacetic acid (EDTA) tube can affect MPV results, so the measurement processing should be done within one h after blood sampling.25

CONCLUSION

Elevation MPV within 24-72 h after being diagnosed (ΔMPV>0) predict poor outcome in pediatric patients with sepsis.

ACKNOWLEDGEMENTS

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