Original Article

**Evaluation of Pentoxifylline in the Prevention of Contrast-Induced Nephropathy in Patients Undergoing Primary Percutaneous Coronary Intervention**

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**ABSTRACT**

**Background:** As percutaneous coronary intervention (PCI) technologies confer increasing patient advantage, the use of iodinated contrast media for diagnostic and interventional procedures is increased. Although contrast media obstacles are transient and mild, contrast-induced nephropathy (CIN) negatively affects long-term patient mortality. PCI creates a high-risk condition for the incidence of CIN even in patients with a normal renal function. Pentoxifylline (PTX) with a variety of mechanisms may prevent CIN. We sought to assess the positive effect of PTX administration at the beginning prior to contrast media use to 24 hours after PCI to prevent CIN in patients with STEMI.

**Methods:** In this double-blind, single-center, clinical trial, we randomly assigned 296 consecutive patients to the control group (n=148) without PTX and the case group (n=148) with PTX 400 mg/tid at the time of hospitalization to 24 hours after the procedure. Serum creatinine was measured before and 48 hours after the procedure. The occurrence of CIN within 48 hours was our end point. CIN was defined as a 0.5 mg/dL increase or more in serum creatinine or a 25% increase or more above baseline serum creatinine.

**Results:** A total of 296 patients were enrolled in this trial and were randomly assigned to receive either primary PCI plus PTX or only primary PCI. Out of 148 patients who received PTX, only 12.2% were seen to have CIN incidence (>0.5 mg/dL or a 25% increase in the Cr level); however, the difference between the 2 groups regarding CIN was not significant (P=0.4). Out of the 296 patients, only 20 were found to have chronic kidney disease (CKD) (CKD was defined as baseline Cr>1.5); and of those patients, 3 (15%) showed CIN incidence. Nevertheless, the difference between the 2 groups regarding CIN incidence was not significant (P=0.7). The regression test showed that between all confounding factors in the 2 groups of PTX positive and negative, sex and ejection fraction had positive effects on the rise in the Cr level and, consequently, the incidence of CIN (95% CI: 1.60 to 30.85; P=0.01 and 95% CI: 0.92 to 1; P=0.05).

**Conclusions:** Administration of oral PTX to patients with increased risk for CIN scheduled for primary PCI may not reduce the Cr level and thus the occurrence of CIN. Given the higher prevalence of hypotension in the patients without PTX, higher prevalence of CKD in the patients without PTX, and absence of significant difference between the 2 groups regarding the incidence of CIN, PTX had no preventive effect on CIN occurrence in STEMI.
Among all factors influencing CIN occurrence, sex and ejection fraction had positive effects on the rise in the Cr level. *(Iranian Heart Journal 2015; 16(4): 28-34)*

**Keywords** ■ Contrast media ■ Primary PCI ■ Contrast-induced nephropathy■ Pentoxifylline

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**METHODS**

**Study Populations**

In the present clinical trial, 296 patients (236 male and 60 female; age >20 y) with STEMI who underwent primary PCI in our tertiary research center between 2013 and 2015 and were considered for emergency coronary angiography and intervention and were candidates for primary PCI were enrolled. A history of taking CM within the previous 10 days and N-acetylcysteine use was considered the exclusion criterion. The patients were divided into 2 groups: those who underwent PCI and did not receive PTX and those who received PTX in addition to their routine drugs. All the patients gave informed written consent before entering the study. The study protocol was approved by the institutional ethics committee. Age, sex, diabetes mellitus, hyperlipidemia, hypertension, hypotension, intravenous contrast volume, use of intra-aortic balloon pump, and chronic kidney disease (CKD) were considered as the study variables.
**Study Protocol**

In this prospective, randomized, double-blind, clinical trial, 296 patients were randomly assigned to the control group (n=148) with routine treatment and no PTX and the study group (n=148) with routine treatment and PTX (400 mg/tid) from the initiation of the study to 24 hours after the procedure; no placebo was administered. Controls were selected randomly out of the patients who came to our hospital and underwent primary PCI and who did not receive PTX, and the cases were selected from the cases that underwent primary PCI and received PTX.

The study and control groups had the same routine preparation protocol for angioplasty as hydration before and after angioplasty with normal saline (1-1.5 cc/kg), which was administered at the start of the study to 12 hours after the procedure.

In all the patients, baseline serum creatinine was measured using Beckman Coulter SYNCHRON CX® PRO Clinical System before angioplasty. One sample serum creatinine was obtained 48 hours after the procedure in all the patients. Measurements were all made in a single center-based laboratory, and the laboratory staff was blinded to the study protocol and serum samples. The choice of the type of CM was left to the interventional cardiologist performing the procedure.

The coronary angioplasty procedures were carried out using the iso-osmolar nonionic CM, iodixanol (Vesipaque 320, GE Healthcare, Cork, Ireland) or iopromide (Ultravist 300, Schering AG, Germany). The primary end point of the study was the occurrence of CIN, which was defined as an increase in serum creatinine level of 0.5 mg/dL or a 25% increase over the baseline creatinine level over a 2-day period after exposure to CM.

**Statistical Analysis**

The continuous data are expressed as means ± standard deviations and they were compared between the 2 groups using the Student t-test. The categorical data are expressed as numbers and percentages and they were compared via the chi-square test. The Mann–Whitney U test was employed to assess the Cr level between the 2 groups. The regression linear test was used to remove the confounding effect of the variables. A P value <0.05 was considered significant. The data were analyzed using SPSS software 13.0 (SPSS Inc. Chicago, Illinois, U.S.A.).

**RESULTS**

A total of 296 patients were enrolled in this trial and were randomly assigned to receive either routine treatment plus PTX (n=148, 117 [79.1%] male; P=0.7) or only routine treatment (n=148). Out of the 148 patients who received PTX, 65 (43.9%) had hypertension (P=0.7), 43 (29.1%) had dyslipidemia (P=0.3), 10 (6.8%) had hypotension (P=0.04), and 49 (33.1%) had diabetes mellitus (P>0.99). All the demographic data and clinical findings are depicted in Table 1 and Table 2.

**Table 1. Patients’ demographic data**

<table>
<thead>
<tr>
<th>Risk factors</th>
<th>Pentoxifylline- (n=148)</th>
<th>Pentoxifylline+ (n=148)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>58.2±12.5</td>
<td>58.4±10</td>
<td>0.89</td>
</tr>
<tr>
<td>Sex</td>
<td>Female</td>
<td>Male</td>
<td></td>
</tr>
<tr>
<td>DLP</td>
<td>51(34.5%)</td>
<td>43(29.1%)</td>
<td>0.31</td>
</tr>
<tr>
<td>HTN</td>
<td>68(45.9%)</td>
<td>65(43.92%)</td>
<td>0.04</td>
</tr>
<tr>
<td>FH</td>
<td>20(13.5%)</td>
<td>30(20.3%)</td>
<td>0.12</td>
</tr>
<tr>
<td>DM</td>
<td>49(33.1%)</td>
<td>49(33.1%)</td>
<td>0.99</td>
</tr>
</tbody>
</table>

Abbreviations: DLP, Dyslipidemia; HTN, Hypertension; FH, Familial history; DM, Diabetes mellitus; CS, Cigarette smoking. P<0.05 was considered the level of significance.
Table 2. Clinical and procedural findings according to pentoxifylline administration

<table>
<thead>
<tr>
<th>Risk factors</th>
<th>Pentoxifylline – (n=148)</th>
<th>Pentoxifylline + (n=138)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypotension</td>
<td>2(3%)</td>
<td>10 (6.8%)</td>
<td>0.04</td>
</tr>
<tr>
<td>IABP</td>
<td>2(1.4%)</td>
<td>4(2.7%)</td>
<td>0.6</td>
</tr>
<tr>
<td>LVEF&lt;40%</td>
<td>61(41.2%)</td>
<td>65(43.9%)</td>
<td>0.63</td>
</tr>
<tr>
<td>CHF</td>
<td>11(7.4%)</td>
<td>11(7.4%)</td>
<td>0.99</td>
</tr>
<tr>
<td>Anemia</td>
<td>26(17.6%)</td>
<td>23(15.5%)</td>
<td>0.63</td>
</tr>
<tr>
<td>Contrast volume</td>
<td>240±99</td>
<td>240±91</td>
<td>0.31</td>
</tr>
<tr>
<td>CKD</td>
<td>10(6.8%)</td>
<td>3(2%)</td>
<td>0.04</td>
</tr>
</tbody>
</table>

Abbreviations: IABP, Intra-aortic balloon pump; CHF, Congestive heart failure; LVEF, Left ventricular ejection fraction; CKD, Chronic kidney disease; P<0.05 was considered the level of significance.

Out of the 148 patients who received PTX, only 18 (12.2%) were seen to have CIN incidence (Cr level >0.5 mg/dL or a rise >25%); however, the difference between the 2 groups regarding CIN was not significant. Out of the 148 patients who did not receive PTX, 22 (14.9%) showed CIN incidence (P=0.4) (Table 3).

Table 3. Occurrence of CIN according to the total Cr level (>0.5 mg/dL and a 25% rise)

<table>
<thead>
<tr>
<th>± PTX</th>
<th>CIN+ Total</th>
<th>CIN– Total</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cr≥0.5 mg/dL Cr≥25%</td>
<td>Cr &lt;0.5 Cr&lt;25%</td>
<td></td>
</tr>
<tr>
<td>Without PTX n=148</td>
<td>22 (14.9%)</td>
<td>126 (85.1%)</td>
<td>0.4</td>
</tr>
<tr>
<td>With PTX n=138</td>
<td>18 (12.2%)</td>
<td>130 (87.2%)</td>
<td></td>
</tr>
</tbody>
</table>

Abbreviations: PTX, Pentoxifylline; CIN, Contrast-induced nephropathy; P<0.05 was considered the level of significance.

Out of the 296 patients, 256 (86.5%) showed no CIN incidence, defined as CIN total (0.5≤CIN or 25%≤CIN) and only 40 patients were found with CIN incidence. Out of the 296 patients, only 20 were found to have CKD (CKD were defined as baseline CR >1.5); and of those patients, 3 (15%) showed CIN incidence. The difference, however, between the 2 groups concerning CIN incidence was not significant (P=0.7). Out of the 276 patients who were CKD negative (Cr level <1.5), 239 (86.6%) did not show CIN incidence (Table 4).

Table 4. Occurrence of CKD according to the Cr level (≥1.5)

<table>
<thead>
<tr>
<th>± CKD</th>
<th>CIN+ Total</th>
<th>CIN– Total</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cr≥0.5 mg/dL Cr≥25%</td>
<td>Cr &lt;0.5 Cr&lt;25%</td>
<td></td>
</tr>
<tr>
<td>CKD+</td>
<td>3(15%)</td>
<td>17(85%)</td>
<td>0.8</td>
</tr>
<tr>
<td>CKD–</td>
<td>37(13.4%)</td>
<td>239(86.6%)</td>
<td></td>
</tr>
</tbody>
</table>

Abbreviations: CKD, Chronic kidney disease; PTX, Pentoxifylline; P<0.05 was considered the level of significance.

The regression model showed that between all the confounding factors in the 2 groups, sex and ejection fraction had positive effects on the rise in the Cr level and consequently the incidence of CIN (95% CI: 1.60 to 30.85; P=0.01 and 95% CI: 0.92 to 1; P=0.05).

DISCUSSION

PTX can be effective in preventing CIN given its anti-inflammatory, antioxidant, and circulatory properties. There are a few animal studies concerning the renoprotective effect of PTX in contrast nephropathy. A few human studies for the evaluation of the renoprotective effect of PTX in contrast nephropathy have been reported.7,13 Our study is one of the few studies conducted hitherto on the effects of PTX on CIN.

A major problem after CM-required procedures is CIN, which is generally characterized as either an absolute increase in serum creatinine (SCr) concentration of 0.5
mg/dL (44.2 1 mol/L) or a relative rise >5% from baseline. CIN typically and clinically manifests within 3 days of CM administration, peaks within 3 to 5 days, and returns to its baseline level within 10 to 21 days. Nevertheless, in some cases, sustained or permanent nephropathy occurs. It is recommended that SCR measurements be continued for >48 hours after exposure to CM to monitor for CIN.

In a trial, CKD was defined as SCR>1.5 mg/dL and was also the strongest predictor of all-cause mortality. An analysis of more than 130,000 elderly post-MI patients found that 1-year survival was increasingly reduced as creatinine clearance declined.

In an investigation, CKD was compared with normal renal function at baseline level in patients with acute myocardial infarction who underwent PCI and was related to an obvious increase in the mortality rate over a 30-day period (7.5% vs. 0.8%; P<0.0001) and at 1 year (12.7% vs. 2.4%; P<0.0001); nevertheless, the additional burden of CIN in patients undergoing PCI with previously compromised renal function apparently increases the risk of adverse outcomes.

Patients undergoing PCI with pre-existing renal dysfunction are at increased risk for adverse outcomes in comparison to those with a normal renal function. The present study showed that the incidence of CIN was 13.5%, which is almost similar to the rate reported by the previous studies. CIN incidence was reported 1-13% in elective PCI or 19% in the Marenzi study. The incidence of CIN in primary PCI in our study showed that there was no significant increase in CIN after STEMI. We think that this is because of better preventive management in 12-hour hydration in our center, which is a high-volume and referral center for primary PCI with optimal arrangements for primary PCI, which results in the earlier reperfusion of occluded vessels and less hemodynamic burden of myocardial infarction.

The overall incidence of CIN in the control group of a previous study was 13.69%, which is comparable to previous reports in an unselected population and less than the CIN incidence in our study.

In the current study, out of the 148 patients who received PTX, only 10 (6.84%) had hypotension and there was a significant relationship between the 2 groups apropos hypotension (P=0.04). Nonetheless, due to the small sample size, it was only seen in a small group of our study population. In a study by Firouzi et al. in patients who underwent angioplasty, it was shown that the oral use of PTX could be recommended for CIN prevention and that it had prophylactic effects, although no statistically significant protective effect was documented. The result of their study was in accordance with our investigation. In the present study, out of the 148 patients who did not receive PTX, only 22 (14.9%) showed CIN incidence (P=0.4). Therefore, the administration of PTX had no statistically significant effects. Out of the 296 patients, only 40 were found to have CIN incidence. Out of the 296 patients, only 20 were found to have CKD (CKD were defined as baseline Cr >1.5); and of those patients, 3 (15%) showed CIN incidence (P=0.7).

The regression test revealed that between all the confounding factors in the 2 groups, sex, and ejection fraction had positive effects on the rise in the Cr level and, thus, the incidence of CIN (P=0.01 and P=0.05, respectively). The difference between the present study and the other investigations regarding the beneficial effect of PTX in the prevention of CIN incidence may be due to the different sizes of the study populations. Our results demonstrated that PTX was a useful drug in the prevention of the negative effects of CM and that it had no preventive effects on the alteration in the Cr level and, consequently, CIN incidence.
**Limitations**
The most important limitation of this small and short-term trial study is the lack of sample-size calculation, which resulted in estimating the small sample size on the basis of other similar trials. We suggest that larger studies be conducted on the effect of PTX.

**CONCLUSIONS**
The present clinical trial utilized PTX for CIN prevention and the results suggested that the administration of oral PTX to patients with a high risk of CIN scheduled for angioplasty might not reduce the Cr level and, thus, the occurrence of CIN. Given the higher prevalence of hypotension in the PTX-negative group, higher prevalence of CKD in the patients without PTX, and the absence of a significant difference between the 2 groups regarding the incidence of CIN, PTX had no preventive effects on CIN occurrence in STEMI. Among all the factors influencing CIN occurrence, sex and ejection fraction had positive effects on the rise in the Cr level and, thus, the occurrence of CIN.

**Suggestion**
Measures before, during, and after the use of CM that reduce the incidence of CIN such as discontinuation of nephrotoxic medications, adequate hydration, and use of appropriate volumes and types of CM should be considered in all patients with renal insufficiency or with other risk factors for CIN. Larger trials or studies in higher-risk patients may shed further light on the protective effect of PTX in CIN.

**Acknowledgements**
We thank Dr. Mona Heidarali for her scientific writing of the manuscript. We also thank Dr. Hooman Bakhshandeh for his valuable efforts in assisting with data analysis and consultation.

**Financial Disclosure**
All the authors declare no conflict of interest. The study complies with the current ethical considerations. Informed consent was obtained from the whole study population.

**Funding/Support**
This project was financially supported by Iran University of Medical Sciences.

**REFERENCES**
9. Staudinger T, Presterl E, Graninger W, Locker GJ, Knapp S, Laczika K et al. Influence of pentoxifylline on cytokine levels and
inflammatory parameters in septic shock.
Intensive Care Med. 1996; 22(9):888-93


