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***Retrospective Study***

**Efficacy and safety of Nafamostat mesylate in patients with end-stage renal failure**

Liu K *et al*. Efficacy and safety of Nafamostat mesylate

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**Abstract**

BACKGROUND

Recent studies on dialysis anticoagulation therapy in patients with renal failure have shown that Nafamostat mesylate, a broad-spectrum potent serine protease inhibitor, has strong anticoagulation and anti-fiber activity.

AIM

To evaluate the efficacy and safety of Nafamostat mesylate in patients with end-stage renal failure.

METHODS

Seventy-five patients with end-stage renal failure who received hemodialysis at our hospital between January 2020 and August 2021 were selected and divided into the observation group (Nafamostat mesylate for injection, *n* = 33) and control group (heparin sodium injection, *n* = 32). General patient data, indicators of clinical efficacy, dialyzer hemocoagulation parameters, coagulation function indices, and hemoglobin concentration and platelet count before and after treatment, and the occurrence of adverse reactions after treatment were compared between the two groups.

RESULTS

The two groups showed no significant differences ingeneral patient data (*P* > 0.05). The post-treatment effectiveness rate in the control group was lower than that in the observation group (*P* < 0.05). The two groups showed no significant difference in the number of patients in grade I (*P* > 0.05), while the number of patients in grade 0 was lower in the control group, and the number of patients in grades II and III was higher in the control group (*P* < 0.05). The post-treatment prothrombin time, activated partial thromboplastin time, thrombin time, and international normalized ratio values in the control group were higher than those in the observation group, while the fibrinogen level in the control group was lower than that in the observation group (*P* < 0.05). The two groups showed no significant difference in the platelet count and hemoglobin level before and after treatment (*P* > 0.05). The total number of post-treatment adverse reactions in the observation group was lower than that in the control group (*P* < 0.05).

CONCLUSION

Treatment of patients showing end-stage renal failure with Nafamostat mesylate can significantly improve therapeutic efficacy and has high safety and clinical value.

**Key Words:** End-stage renal failure; Nafamostat mesylate; Effectiveness; Safety study; Chronic kidney diseases

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**Core Tip:** End-stage renal disease refers to the terminal stage of the progression of various chronic kidney diseases, such as chronic nephritis, nephrotic syndrome, and tubulointerstitial disease. We aimed to evaluate the efficacy and safety of Nafamostat mesylate in patients with end-stage renal failure. Treatment of patients showing end-stage renal failure with Nafamostat mesylate can significantly improve therapeutic efficacy and has high safety and clinical value.

**INTRODUCTION**

End-stage renal disease (ESRD) refers to the terminal stage of the progression of various chronic kidney diseases, such as chronic nephritis, nephrotic syndrome, and tubulointerstitial disease[1]. However, the early clinical stages of end-stage renal failure do not show any obvious symptoms. With the progression of the disease, limb edema, fatigue, gastrointestinal bleeding, and other symptoms gradually appear, and patients may show more serious symptoms and even life-threatening conditions such as consciousness disorders and cardiac arrest[2]. At present, the disease is incurable, and continuous renal replacement therapy is mainly used to prolong patient survival. However, filter coagulation during dialysis treatment can cause adverse events such as treatment interruption, additional blood loss, and inadequate dialysis, which affects the clinical treatment efficacy and increases equipment costs, highlighting the importance of appropriate anticoagulant therapy[3,4]. Anticoagulant therapy offers the advantage of maintaining extracorporeal circuit patency and reducing the rate of complications. Proteases are enzymes that hydrolyze the amide bonds of polypeptides and protein peptide units, and are involved in the pathogenesis of various diseases, including pancreatitis with trypsin and kinin-releasing enzymes, thrombin and plasmin-mediated disseminated intravascular coagulation syndrome, and autoimmune diseases mediated by the complement system[5]. Recent studies on dialysis anticoagulation therapy in patients with renal failure have shown that Nafamostat mesylate, a broad-spectrum potent serine protease inhibitor, has strong anticoagulation and anti-fiber activity, but Nafamostat mesylate has a short history of use in Linchuan, China, and the relevant literature is limited[6]. We discuss the efficacy and safety of Nafamostat mesylate in patients with end-stage renal failure.

**MATERIALS AND METHODS**

***General information***

A total of 75 patients with ESRD undergoing hemodialysis between January 2020 and August 2021 were selected and divided into the observation group (Nafamostat mesylate injection, *n* = 33) and control group (heparin sodium injection, *n* = 32). The observation group consisted of 17 male and 16 female patients aged 50-81 yr (mean age, 66.98 ± 6.45 yr), including 10 patients with chronic nephritis, 9 with nephrotic syndrome, 5 with tubulointerstitial disease, and 9 with other diseases. In contrast, the control group consisted of 18 male 14 female patients aged 52-82 yr (mean age, 67.13 ± 6.13), including 11 patients with chronic nephritis, 7 with nephrotic syndrome, 4 with tubulointerstitial disease, and 10 with other diseases. Comparison of the relevant baseline characteristics in the two groups did not show any significant differences (*P* > 0.05).

The inclusion criteria were as follows: (1) Availability of complete clinical data; (2) Meeting the relevant diagnostic criteria for end-stage renal failure diagnosis[7]; and (3) The patients were informed about the study, and informed consent was obtained from the patients and their families.

Exclusion criteria: (1) Could not participate in the entire research process; (2) Showed coinfection and other systemic diseases or organic lesions; (3) Had hematological diseases; or (4) Lack of consciousness and mental illness.

***Dialysis protocol***

All patients underwent treatment with a Prismaflex hemodialysis machine (Golden Baxter, Sweden) in the continuous venovenous blood-filtration mode.

***Anticoagulation method***

The steps involved in the anticoagulation protocol are listed below.

Pipeline pre-charge: after 0.9% sodium chloride injection, the observation group received naphthylostat (Nafamostat mesylate 20 mg, from Jiangsu Durui Pharmaceutical Co., LTD., H20203509) in 500 mL of 0.9% sodium chloride solution, while the control group received 500 mL of a solution containing 20 mg heparin sodium (Hebei Kaiwei Pharmaceutical Co., LTD., H20153264) in a pre-filled dialysis line and dialyzer.

During hemodialysis, the observation group followed the routine dosage of subjects (all subjects received intravenous injection of 60-80 IU/kg low molecular weight heparin sodium or an intravenous first dose of ordinary heparin 0.3-0.5 mg/kg before treatment followed by continuous infusion at 5-10 mg/h. The supplementation was stopped 1 h before the end of treatment with individual adjustments), with nafamostat 20 mg/h to 50 mg/h, continuous infusion from the arterial end of the CPB pipeline to the end of dialysis, the control group gave the first dose of heparin sodium 0.3-0.5mg/kg, at a dose of 5 mg/h to 10 mg/h, continuous infusion, additional heparin sodium was stopped 1 h before the end of hemodialysis treatment[8,9].

***Sample collection***

Cubital venous blood (6 mL) was collected in the morning, placed in a vacuum centrifuge tube, shaken till it mixed well, and centrifuged at 3000 r/min for 10 min. After obtaining the serum from the upper layer, (Changsha Chuxiang Biotechnology Co., Ltd.) fibrinogen (FIB) was detected by immunoturbidimetry; prothrombin time (PT), activated partial thromboplastin time (APTT), thrombin time (TT), and the international normalized ratio (INR) were measured by coagulation analyses; and the hemoglobin (HGB) concentration and platelet (PLT) count were determined using a fully automated blood analyzer. All tests were conducted by professional examiners in strict accordance with the instructions.

***Observational indicators***

**Comparing the two groups of general data:** These include gender (male/female), age, cause of disease (chronic nephritis, nephrotic syndrome, tubulointerstitial disease and others), *etc.*

**Comparison of clinical efficacy:** Clinical efficacy was categorized as described below. Significant: the filter shows no coagulation, coagulation function indices remain unchanged, and the patient shows no spontaneous bleeding or other clinical symptoms.

Effective: the filter shows no coagulation, the coagulation function indices decrease slightly, and the patient shows no clinical complications.

Ineffective: the filter shows coagulation, no coagulation function index, and the patient shows clinical complications.

The total efficacy rate was calculated as follows: total efficacy rate = (effective + significant)/100% of total cases[10].

**Comparison of coagulation status of the two groups:** The detailed evaluation criteria for this comparison are listed below.

Grade 0: no coagulation or several pieces of coagulation fibers.

Grade I: less than 10% fibrous coagulation or bundled fibrous coagulation.

Grade II: less than 50% fibrous coagulation or severe coagulation.

Grade III: more than 50% fibrous coagulation, significantly increased venous pressure, or cases requiring dialyzer replacement[11].

**Comparison of coagulation function indices:** The PT, APTT, TT, INR, and FIB level were compared between the two groups. The normal ranges of PT, APTT, TT, INR, and FIB level were 11-15 s, 25-37 s, 16-18 s, 0.8-1.5 s, and 2-4 g/L, respectively[12].

**Comparison of hematological parameters:** The HGB level and PLT count were compared before and after the treatment in the two groups. The normal HGB level is 110-150 g/L, while the normal PLT count is 100-300 × 109/L[13].

**Comparison of post-treatment adverse reactions:** The occurrence of adverse reactions, including skin rash, nausea, dizziness, palpitations, diarrhea, fever, chest tightness, and dyspnea, was compared between the groups.

***Statistical analysis***

Statistical analyses were performed using SPSS 18.0. Measurement data were expressed as mean ± SD and compared using the *t*-test, while count data were expressed as *n* (%) and compared using the *χ2* test; all data were considered statistically significant at *P* < 0.05.

**RESULTS**

***General information***

A comparison of the general data between the two groups showed no statistically significant differences (*P* > 0.05; Table 1).

***Clinical efficacy***

The total response rate in the control group was lower than that in the observation group (*P* < 0.05; Table 2).

***Blood coagulation status of the dialyzer***

After treatment, the proportion of grade I cases did not differ significantly between the two groups (*P* > 0.05). However, the control group showed a lower proportion of grade 0 cases and a higher proportion of grade II and III cases than the observation group (*P* < 0.05; Table 3).

***Blood coagulation indices***

Before treatment, the PT, APTT, TT, INR, and FIB level did not differ significantly between the groups (*P* > 0.05). However, the post-treatment PT, APTT, TT, INR, and FIB level were significantly lower in the control group (*P* < 0.05; Table 4).

***Hematological indices***

The two groups showed no significant difference in the PLT count and HGB level (*P* > 0.05; Table 5).

***Adverse reactions***

The total number of adverse reactions in the observation group was lower than that in the control group (*P* < 0.05; Table 6).

**DISCUSSION**

Blood-filtration treatment in patients with ESRD is associated with the risk of bleeding when anticoagulants such as common heparin and low molecular weight heparin are used. However, treatment without anticoagulant drugs can result in serious coagulation episodes, inadequate dialysis, and other complications[14].

Some studies from China have reported that anticoagulant treatment with heparin sodium injection can avoid coagulation of the filter in blood-filtration treatment, but heparin sodium injections can cause clinical symptoms such as spontaneous bleeding and fever, impeding the curative effects[15]. In this regard, studies in other countries using nafamostat injection for patients undergoing blood filtration showed that the drug has a rapid onset, short half-life, fast metabolism, and favorable anticoagulant effects, and that its effectiveness is better than that of ordinary anticoagulant drugs[16]. Consistent with these findings, our results showed that the total response rate in the control group was lower than that in the observation group (*P* < 0.05), indicating that the clinical efficacy of Nafamostat mesylate was better. Moreover, foreign studies have reported that the anticoagulant activity of Nafamostat mesylate is more than two times that of ordinary anticoagulant drugs, and because of its short half-life, it can improve the life of the filter[17]. Our results showed that while the two groups did not differ in the proportion of grade I cases (*P* > 0.05), the control group showed a lower proportion of grade 0 cases and a higher proportion of grade II and III cases than the observation group (*P* < 0.05), which was consistent with the findings of the previous studies and indirectly confirmed that the anticoagulant effects of Nafamostat mesylate are better than those of heparin sodium. This may be attributed to the delayed onset of the effects of heparin sodium and its long half-life, which cannot guarantee the life of the filter, potentially causing filter coagulation[18].

The results of this study showed that despite the absence of significant pre-treatment differences in the PT, APTT, TT, INR, and FIB level between the two groups (*P* > 0.05), the control group showed higher PT, APTT, TT and INR values and a lower FIB level than the observation group post-treatment (*P* < 0.05). In contrast, the PLT count and HGB levels did not differ significantly between the two groups (*P* > 0.05). These findings together demonstrate that while Nafamostat mesylate improved coagulation levels in patients better than heparin sodium, it had no obvious effect on the PLT count and HGB level, indicating a favorable safety profile. The PLT count and HGB level are often reduced by common heparin anticoagulant therapy, leading to the occurrence of severe anemia. In contrast, Nafamostat mesylate mainly inhibits various enzymes in the coagulation process to show good anticoagulation effects; thus, it only affects coagulation function and does not show obvious effects on the PLT count and HGB levels of the patients[19,20]. Moreover, a 3-yr retrospective study conducted abroad confirmed that naphlimostat can guarantee sufficient filter life without causing serious bleeding, fever, and other complications; thus, the study concluded that Nafamostat mesylate minimizes the risk of coagulation and is safe and effective, making it less risky than heparin sodium anticoagulant therapy[19]. The results of this study showed that the total number of adverse reactions in the observation group was lower than that in the control group (*P* < 0.05), which was consistent with the findings of the retrospective study and indicated that Nafamostat mesylate reduced the incidence of adverse reactions and had higher safety. However, the study still has some limitations. First, the findings may be biased due to the small sample size. Future studies could employ larger RCT trials to reduce bias and increase study reliability. Meanwhile, the long-term efficacy of patients should be evaluated and the treatment efficacy of different patient groups should be considered.

**CONCLUSION**

In conclusion, treatment with Nafamostat mesylate in patients with ESRD showed significantly improved treatment efficacy with high safety and high clinical potential.

**ARTICLE HIGHLIGHTS**

***Research background***

Recent studies on anticoagulation on dialysis in patients with renal failure suggest, Nafamostat mesylate, a broad-spectrum highly potent serine protease inhibitor with potent anticoagulation and antifibrous activity, with a significant anticoagulant effect.

***Research motivation***

In the early clinical stage of terminal renal failure, there are no obvious symptoms. With the progression of the disease, limb edema, fatigue, gastrointestinal bleeding and other symptoms gradually appear, and more serious and even consciousness disorders and cardiac arrest, seriously endangering the life of the patient.

***Research objectives***

Efficacy and safety of Nafamostat mesylate in patients with end-stage renal failure.

***Research methods***

It was divided into observation group and control group. The clinical efficacy indicators of the two groups were compared.

***Research results***

While the number of patients in grade 0 was lower in the control group, and the number of patients in grades II and III was higher in the control group (*P* < 0.05). The post-treatment prothrombin time, activated partial thromboplastin time, thrombin time, and international normalized ratio values in the control group were higher than those in the observation group.

***Research conclusions***

The use of Nafamostat mesylate in patients with end-stage renal failure can significantly improve the treatment effect and have high safety and clinical value.

***Research perspectives***

We discuss the efficacy and safety of Nafamostat mesylate in patients with end-stage renal failure.

**REFERENCES**

1 **Ghali GZ**, Ghali MGZ. Nafamostat mesylate attenuates the pathophysiologic sequelae of neurovascular ischemia. *Neural Regen Res* 2020; **15**: 2217-2234 [PMID: 32594033 DOI: 10.4103/1673-5374.284981]

2 **Hernández-Mitre MP**, Tong SYC, Denholm JT, Dore GJ, Bowen AC, Lewin SR, Venkatesh B, Hills TE, McQuilten Z, Paterson DL, Morpeth SC, Roberts JA. Nafamostat Mesylate for Treatment of COVID-19 in Hospitalised Patients: A Structured, Narrative Review. *Clin Pharmacokinet* 2022; **61**: 1331-1343 [PMID: 36040613 DOI: 10.1007/s40262-022-01170-x]

3 **Soma T**, Fujii K, Yoshifuji A, Maruki T, Itoh K, Taniyama D, Kikuchi T, Hasegawa N, Nakamura M. Nafamostat Mesylate Monotherapy in Patients with Moderate COVID-19: a Single-Center, Retrospective Study. *Jpn J Infect Dis* 2022; **75**: 484-489 [PMID: 35491224 DOI: 10.7883/yoken.JJID.2021.699]

4 Retraction: Nafamostat mesylate attenuates the pathophysiologic sequelae of neurovascular ischemia. *Neural Regen Res* 2022; **17**: 958 [PMID: 34558547 DOI: 10.4103/1673-5374.295353]

5 **Lin YT**, Lin J, Liu YE, Hsu KW, Hsieh CC, Chen DR, Wu HT. Nafamostat mesylate overcomes endocrine resistance of breast cancer through epigenetic regulation of CDK4 and CDK6 expression. *Transl Oncol* 2022; **15**: 101302 [PMID: 34890965 DOI: 10.1016/j.tranon.2021.101302]

6 **Ryu HG**, Jung CW, Lee CS, Lee J. Nafamostat mesilate attenuates Postreperfusion Syndrome during liver transplantation. *Am J Transplant* 2011; **11**: 977-983 [PMID: 21521468 DOI: 10.1111/j.1600-6143.2011.03514.x]

7 **Zhao C**, Zhou T, Zhao X, Pang Y, Li W, Fan B, Li M, Liu X, Ma L, Zhang J, Sun C, Shen W, Kong X, Yao X, Feng S. Delayed administration of nafamostat mesylate inhibits thrombin-mediated blood-spinal cord barrier breakdown during acute spinal cord injury in rats. *J Neuroinflammation* 2022; **19**: 189 [PMID: 35842640 DOI: 10.1186/s12974-022-02531-w]

8 **Matsumoto T**, Okuwaki K, Imaizumi H, Kida M, Iwai T, Yamauchi H, Kaneko T, Hasegawa R, Masutani H, Tadehara M, Adachi K, Watanabe M, Kurosu T, Tamaki A, Kikuchi H, Ohno T, Koizumi W. Nafamostat Mesylate is Not Effective in Preventing Post-Endoscopic Retrograde Cholangiopancreatography Pancreatitis. *Dig Dis Sci* 2021; **66**: 4475-4484 [PMID: 33495919 DOI: 10.1007/s10620-020-06782-6]

9 **Kim HA**, Kim JE. Development of Nafamostat Mesylate Immediate-Release Tablet by Drug Repositioning Using Quality-by-Design Approach. *Pharmaceutics* 2022; **14** [PMID: 35745792 DOI: 10.3390/pharmaceutics14061219]

10 **Neely JL**, Carlson SS, Lenhart SE. Tinzaparin sodium: a low-molecular-weight heparin. *Am J Health Syst Pharm* 2002; **59**: 1426-1436 [PMID: 12166042 DOI: 10.1093/ajhp/59.15.1426]

11 **Qian W**, He C, Ren Y, Xian X, Jiang Z, Xu S. Application of nafamostat mesylate for anticoagulation in hemoperfusion therapy in patients with bromadiolone poisoning: Case reports. *Heliyon* 2023; **9**: e19811 [PMID: 37809476 DOI: 10.1016/j.heliyon.2023.e19811]

12 **Baek NN**, Jang HR, Huh W, Kim YG, Kim DJ, Oh HY, Lee JE. The role of nafamostat mesylate in continuous renal replacement therapy among patients at high risk of bleeding. *Ren Fail* 2012; **34**: 279-285 [PMID: 22251267 DOI: 10.3109/0886022X.2011.647293]

13 **Iwasaka S**, Shono Y, Tokuda K, Nakashima K, Yamamoto Y, Maki J, Nagasaki Y, Shimono N, Akahoshi T, Taguchi T. Clinical improvement in a patient with severe coronavirus disease 2019 after administration of hydroxychloroquine and continuous hemodiafiltlation with nafamostat mesylate. *J Infect Chemother* 2020; **26**: 1319-1323 [PMID: 32893123 DOI: 10.1016/j.jiac.2020.08.001]

14 **Hwang SD**, Hyun YK, Moon SJ, Lee SC, Yoon SY. Nafamostat mesilate for anticoagulation in continuous renal replacement therapy. *Int J Artif Organs* 2013; **36**: 208-216 [PMID: 23404639 DOI: 10.5301/IJAO.5000191]

15 **Asakura H**, Ogawa H. Potential of heparin and nafamostat combination therapy for COVID-19. *J Thromb Haemost* 2020; **18**: 1521-1522 [PMID: 32302456 DOI: 10.1111/jth.14858]

16 **Inose K**, Ono K, Tsutida A, Onai M, Komai M, Uehara K, Yano S, Naruse T. Active inhibitory effect of nafamostat mesylate against the elevation of plasma myeloperoxidase during hemodialysis. *Nephron* 1997; **75**: 420-425 [PMID: 9127328 DOI: 10.1159/000189579]

17 **Doi K**, Ikeda M, Hayase N, Moriya K, Morimura N; COVID-UTH Study Group. Nafamostat mesylate treatment in combination with favipiravir for patients critically ill with Covid-19: a case series. *Crit Care* 2020; **24**: 392 [PMID: 32620147 DOI: 10.1186/s13054-020-03078-z]

18 **Hifumi T**, Isokawa S, Otani N, Ishimatsu S. Adverse events associated with nafamostat mesylate and favipiravir treatment in COVID-19 patients. *Crit Care* 2020; **24**: 497 [PMID: 32787901 DOI: 10.1186/s13054-020-03227-4]

19 **Sun C**, Li B, Duan H, Tao B, Zhao C, Li W, Pang Y, Fan B, Feng S. Cytokine expressions of spinal cord injury treated by neurotropin and nafamostat mesylate. *Ann Transl Med* 2021; **9**: 489 [PMID: 33850886 DOI: 10.21037/atm-21-649]

20 **Lin Y**, Shao Y, Liu Y, Yang R, Liao S, Yang S, Xu M, He J. Efficacy and safety of nafamostat mesilate anticoagulation in blood purification treatment of critically ill patients: a systematic review and meta-analysis. *Ren Fail* 2022; **44**: 1263-1279 [PMID: 35930302 DOI: 10.1080/0886022X.2022.2105233]

**Footnotes**

**Institutional review board statement:** This study protocol was approved by the General Hospital of The Yangtze River Shipping, Wuhan Brain Hospital, and all the families have voluntarily participated in the study and have signed informed consent forms.

**Informed consent statement:** All study participants, or their legal guardian, provided informed written consent prior to study enrollment.

**Conflict-of-interest statement:** The authors declared no conflict of interest existing in this paper.

**Data sharing statement:** Data generated from this investigation are available upon reasonable quest from the corresponding author.

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**Table 1 General characteristics of the two groups**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Group** | **Number of patients** | **Sex** | **Cause of disease** | **Age** |
| **Male** | **Female** | **Chronic nephritis, nephrotic syndrome, renal tubulointerstitial disease** | **Others** |
| Observation group | 33 | 17 (51.51) | 16 (48.48) | 24 (72.72) | 9 (27.27) | 66.98 ± 6.45 |
| Control group | 32 | 18 (56.25) | 14 (43.75) | 22 (68.75) | 10 (31.25) | 67.13 ± 6.13 |
| *χ2*/*t* | - | 0.146 | 0.124 | 0.096 |
| *P* value | - | 0.701 | 0.724 | 0.923 |

Data are presented as mean ± SD or *n* (%).

**Table 2 Response rates in the two groups**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Group** | **Number of patients** | **Significant** | **Effective** | **Ineffective** | **Total efficacy rate** |
| Observation group | 33 | 22 (66.66) | 9 (27.27) | 2 (6.06) | 31 (93.93) |
| Control group | 32 | 7 (21.87) | 15 (46.87) | 10 (31.25) | 22 (68.75) |
| *χ2* | - | - | - | - | 6.847 |
| *P* value | - | - | - | - | 0.008 |

Data are presented as *n* (%).

**Table 3 Coagulation status in the two groups**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Group** | **Number of patients** | **Grade 0** | **Grade I** | **Grade II** | **Grade III** |
| Observation group | 33 | 20 (60.60) | 5 (15.15) | 6 (18.18) | 2 (6.06) |
| Control group | 32 | 5 (15.62) | 2 (6.06) | 14 (43.75) | 11 (34.37) |
| *χ2* | - | 13.887 | 1.339 | 0.498 | 8.140 |
| *P* value | - | < 0.001 | 0.247 | 0.025 | 0.004 |

Data are presented as *n* (%).

**Table 4 Coagulation indices in the two groups**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Group** | **PT (s)** | **APTT (s)** | **TT (s)** | **INR (s)**  | **FIB (g/L)** |
| **Pre-treatment** | **Post-treatment** | **Pre-treatment** | **Post-treatment** | **Pre-treatment** | **Post-treatment** | **Pre-treatment** | **Post-treatment** | **Pre-treatment** | **Post-treatment** |
| Observation group (*n* = 33) | 16.25 ± 0.26 | 12.35 ± 0.56b | 40.12 ± 0.13 | 36.65 ± 0.23b | 21.48 ± 0.89 | 17.56 ± 0.48b | 2.31 ± 0.13 | 0.94 ± 0.05b | 6.17 ± 0.19 | 5.26 ± 0.11b |
| Control group (*n* = 32) | 16.29 ± 0.33 | 15.48 ± 0.48b | 40.17 ± 0.19 | 39.48 ± 0.24b | 21.15 ± 0.78 | 20.03 ± 0.26b | 2.32 ± 0.19 | 2.01 ± 0.12b | 6.13 ± 0.56 | 3.26 ± 0.56b |
| *t* | 0.543 | 24.160 | 1.241 | 48.544 | 1.587 | 25.680 | 0.248 | 47.181 | 0.388 | 20.124 |
| *P* value | 0.588 | < 0.001 | 0.219 | < 0.001 | 0.117 | < 0.001 | 0.804 | < 0.001 | 0.699 | < 0.001 |

b*P* < 0.001 in comparison with the pre-treatment value. Data are presented as mean ± SD. PT: Prothrombin time; APTT: Activated partial thromboplastin time; TT: Thrombin time; INR: International normalized ratio; FIB: Fibrinogen.

**Table 5 Hemoglobin level and platelet count in the two treatment groups**

|  |  |  |  |
| --- | --- | --- | --- |
| **Group** | **Number of patients** | **PLT count (× 109/L)** | **HGB level (g/L)** |
| **Pre-treatment** | **Post-treatment** | **Pre-treatment** | **Post-treatment** |
| Observation group | 33 | 41.23 ± 2.08 | 41.45 ± 2.56 | 96.58 ± 1.23 | 96.88 ± 1.11 |
| Control group | 32 | 41.45 ± 1.98 | 41.88 ± 2.43 | 96.45 ± 1.08 | 96.78 ± 1.37 |
| *t* | - | 0.436 | 0.694 | 0.452 | 0.323 |
| *P* value | - | 0.664 | 0.490 | 0.652 | 0.747 |

Data are presented as mean ± SD. PLT: Platelet; HGB: Hemoglobin.

**Table 6 Adverse reactions after treatment in the two groups**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Group** | **Number of patients** | **Autogenous hemorrhage** | **Rash** | **Fever** | **Untoward effect** |
| Observation group | 33 | 1 (3.03) | 0 (0.00) | 0 (0.00) | 1 (3.03) |
| Control group | 32 | 6 (18.75) | 0 (0.00) | 1 (3.12) | 7 (21.87) |
| *χ2* | - | - | - | - | 5.345 |
| *P* value | - | - | - | - | 0.027 |

Data are presented as *n* (%).