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<tr>
<td>Citation</td>
<td>Hong Kong Medical Journal, 2016, v. 22 n. 5, p. 478-485</td>
</tr>
<tr>
<td>Issued Date</td>
<td>2016</td>
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<tr>
<td>URL</td>
<td><a href="http://hdl.handle.net/10722/232059">http://hdl.handle.net/10722/232059</a></td>
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Extracorporeal blood purification for sepsis

HP Shum *, WW Yan, TM Chan

A B S T R A C T

It has been speculated that extracorporeal blood purification therapies might improve the clinical outcome for patients with severe sepsis, with or without acute kidney injury, since the removal of inflammatory mediators and/or bacterial toxins from circulation could modulate the inflammatory responses that result in organ damage. Despite initial enthusiasm based on promising preliminary results, subsequent investigations did not show sustainable survival benefit. We review the principles and development of blood purification techniques for sepsis and septic acute kidney injury.

Introduction

The concepts underlying the pathogenesis of septic acute kidney injury (AKI) are complex. It is characterised by renal macro- and micro-circulatory disturbance, surge of inflammatory markers, and de-regulation of oxidative stress, followed by a bioenergetic adaptive response and controlled cell cycle arrest aimed at preventing cell death. Continuous renal replacement therapy is commonly performed in the critical care setting for patients with septic AKI. The use of low- or normal-volume continuous venovenous haemodialysis or haemofiltration, however, has failed to demonstrate any improvement of patient outcome in severe sepsis. Extracorporeal blood purification therapies have been proposed to improve the outcome for patients with severe sepsis with and without AKI. The underlying principle is the removal of excessive inflammatory mediators and/or bacterial toxins from the blood compartment in order to modulate the inflammatory response. This involves various techniques including haemoperfusion/haemoadsorption, high-adsorption haemofiltration, high-volume haemofiltration (HVHF), high cut-off (HCO) membrane haemofiltration/haemodialysis, plasma exchange, and coupled plasma filtration adsorption (CPFA) [Table 1]. These techniques are gaining popularity in Europe and Japan. This overview discusses the concept and latest advances in blood purification for sepsis and septic AKI.

Therapeutic concept of extracorporeal blood purification

During sepsis, triacylated peptides, diacylated peptides, or lipopolysaccharides (LPS) are released by pathogens, and are recognised by the Toll-like receptors located on the surface of antigen-presenting cells. Toll-like receptors also recognise locally produced damage-associated molecular patterns (DAMPs) from ischaemic renal tissue and circulating DAMPs released from extensive extrarenal tissue damage in sepsis. This triggers the activation of leukocytes, endothelial cells, and epithelial cells that release more inflammatory mediators such as tumour necrosis factor–alpha (TNF-α), interleukin-1 (IL-1), IL-6, IL-8 and IL-10, causing cellular and tissue damage. This is called a ‘cytokine storm’, and can also occur in non-infectious conditions such as severe trauma, extensive burns, acute necrotising pancreatitis, and post–cardiac arrest. A cytokine storm per se, in the absence of life-threatening triggering factors, can induce haemodynamic instability and multi-organ failure as illustrated by Suntharalingam et al. Moreover, immunoparalysis might occur after a cytokine storm and contribute to severe secondary nosocomial infections. As demonstrated in a postmortem by Boomer et al, patients who die of severe sepsis have biochemical and immunohistochemical findings consistent with immunosuppression. This gives rise to the concept of immunomodulation in sepsis. Low-dose steroid administration has been shown to improve septic shock reversal but is not associated with any survival benefits and is currently out of favour. The clinical benefit of intravenous immunoglobulins and anti–TNF-α in the treatment of severe sepsis is controversial and inconclusive. Blood purification may offer non-specific clearance of inflammatory mediators and/or microbial toxins and thus help to restore immune homeostasis. Five theories have been proposed to explain the potential
benefit of blood purification in sepsis. First, Ronco et al\(^1\) proposed the “cytokine peak concentration hypothesis” and suggested that eliminating the peaks in cytokine blood concentration during the early phase of sepsis could stop the inflammatory cascade, limit organ damage, and consequently decrease the incidence of multi-organ failure syndrome. Second, Honoré and Matson\(^2\) proposed the "threshold immunomodulation hypothesis" that indicated cytokines will equilibrate between the blood and tissue compartments. This provided an explanation for the clinical benefit of blood purification techniques even without any significant changes in cytokine level within the blood compartment. Third, Di Carlo and Alexander\(^3\) proposed the “mediator delivery hypothesis” and suggested that high-volume fluid replacement during haemofiltration might promote lymphatic flow and displace inflammatory mediators to the blood compartment, making them available for removal. Fourth, Peng et al\(^4\) suggested that blood purification therapies could act directly at the cellular level to restore immune function. Finally, Rimmelé and Kellum\(^5\) proposed the “cytokinetic model” which indicated that blood purification techniques remove cytokines from the blood compartment and widen the cytokine/chemokine concentration gradient between blood and infected tissue. This improves leukocyte trafficking towards the infective foci, and thus promotes bacterial killing.

### Haemoperfusion/haemoadsorption

This technique binds toxins and other mediators in the extracorporeal circuit and removes them from the blood compartment.\(^6\) The sorbents, which consist of microfibres or resin-covered beads, are normally contained in cartridges that are placed in series within the extracorporeal circuit. They have a selective or non-selective binding capacity for cytokines, chemokines, super-antigens, or endotoxins by means of hydrophobic interaction, van der Waals forces, or ionic interactions.\(^6\) Initial clinical applications were complicated by severe thrombocytopenia and leukopenia but these were

<table>
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<th>TABLE 1. Comparison between major blood purification techniques</th>
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<td><strong>Therapy</strong></td>
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| Polymyxin B-immobilised fibre column (Toraymyxin; Toray Industries, Tokyo, Japan) | Endotoxin haemoadsorption | • Potential mortality benefit based on RCTs  
• Well-studied treatment modality  
• Not available locally |
| MATISSE-Fresenius system (Fresenius SE, Bad Homburg, Germany) | Endotoxin haemoadsorption | • Multicentre RCT showed no significant clinical benefit |
| Alteco LPS Adsorber (Alteco Medical AB, Lund, Sweden) | Endotoxin haemoadsorption | • Limited clinical experience  
• Ex-vivo study showed unacceptable LPS clearance |
| Cytokines haemoadsorptive device | Cytokine haemoadsorption | • Good cytokine clearance  
• Limited clinical experience |
| oXiris haemofilter (Gambro Hospal, Stockholm, Sweden) | Endotoxin and cytokine haemoadsorption plus renal support | • Simple and familiar technique  
• Limited clinical experience |
| PMMA haemofilter | Cytokine haemoadsorption plus renal support | • Simple and familiar technique  
• No RCT available  
• Low cost |
| HVHF | Haemofiltration | • Well-studied treatment modality  
• No survival or haemodynamic benefit |
| High cut-off haemofiltration/haemodialysis | Cytokine removal by haemofiltration/haemodialysis | • Simple and familiar technique  
• One unpublished RCT showed no mortality or other clinical benefit |
| Plasmapheresis | Cytokine removal by haemofiltration | • Conflicting results from RCTs  
• Loss of vital component during prolonged treatment |
| CPF A | Cytokine removal by haemofiltration and haemoadsorption | • One RCT showed no mortality benefit  
• More complicated setup when compared with other blood purification techniques |

Abbreviations: CPFA = coupled plasma filtration adsorption; HVHF = high-volume haemofiltration; LPS = lipopolysaccharides; PMMA = polymethylmethacrylate; RCT = randomised controlled trial
subsequently managed using a biocompatible coating.

**Polymyxin B–immobilised fibre column**

Polymyxin B (PMX)–immobilised fibre column haemoperfusion (Toraymyxin, Toray Industries, Tokyo, Japan) is the most commonly used approach, and has been used for the treatment of septic shock since 1994 in Japan and since 2002 in Europe. It has gained popularity worldwide in recent years, especially after the landmark EUPHAS (Early Use of Polymyxin B Hemoperfusion in Abdominal Sepsis) study. The PMX is a group of cyclic cationic polypeptide antibiotics derived from Bacillus polymyx. Endotoxins are heat and pH stable, and thus can be difficult to remove from protein-rich solutions such as blood. The PMX is capable of binding and neutralising endotoxins. Nephrotoxicity and neurotoxicity, however, are very common and thus limit their clinical use. To overcome this problem, PMX is immobilised onto polystyrene fibres that effectively remove endotoxin without leaching. The blood is perfused at a rate of 80 to 100 mL/min through a PMX-immobilised fibre column. Anticoagulation is achieved using unfractionated heparin, low-molecular-weight heparin, or the protease inhibitor nafamostat mesylate. Treatment usually lasts for 2 to 27 hours once or in some patients up to 4 times, depending on the clinical response. Three meta-analyses (approximately 1000 patients) were published before 2015: Studies by Mitaka and Tomita (17 studies, 975 patients) and Cruz et al (28 studies, 1425 patients) included both randomised controlled trials (RCTs) and observational studies. When reported, Gram-negative infections were identified in approximately 70% of patients (range, 37.9%-100% in individual studies). In general, PMX treatment led to significant haemodynamic improvement with a reduction in the use of inotropic agents/vasopressors in patients with sepsis. Moreover, it was associated with a decreased endotoxin level, modulation of inflammatory markers, and improvement of the PaO₂/FiO₂ ratio (ratio of the partial pressure of oxygen in arterial blood to the inspired oxygen fraction) in most included studies. Treatment by PMX significantly reduced 28-day mortality compared with conventional therapy. The meta-analysis by Zhou et al (8 studies, 370 patients) included RCTs only and focused on mortality, and showed significant survival benefit compared with conventional treatment. Only a few clinically important adverse effects were reported during PMX haemoperfusion, including cartridge clotting, hypotension, and hypersensitivity. Nonetheless, the largest multicentre RCT (232 patients) testing the performance of PMX haemoperfusion in peritonitis-induced septic shock was published in April 2015, and reported contrasting findings. No significant differences in 28-day mortality (27.7% in PMX-treated group vs 19.5% in controls; P=0.14), haemodynamic patterns, or organ failure evolution were observed. This negative result was similar to a large retrospective study (642 patients) by Iwagami et al who examined the effect of postoperative PMX haemoperfusion on peritonitis-induced septic shock. Patients treated with one or two PMX haemoperfusion sessions showed similar mortality at day 28 (17%) to propensity-matched patients without PMX treatment (16.3%). EUPHRATES (safety and efficacy of PMX haemoperfusion for septic shock study), a very large multicentre US-based phase III trial in patients with confirmed endotoxaemia, is currently underway and results should be available after July 2017. Based on current evidence, the clinical benefit of PMX haemoperfusion in Gram-negative sepsis is unclear. Moreover, the cost of individual haemoperfusion cartridges is very high (approximately HK$40 000 per cartridge) and limits its clinical use in local settings. Currently, PMX-immobilised fibre column haemoperfusion is not available in Hong Kong.

**MATISSE-Fresenius system**

The MATISSE-Fresenius system (Fresenius SE, Bad Homburg, Germany) binds endotoxins to human albumin. The extracorporeal circuit is maintained by the Fresenius haemoadsorption machine using the MATISSE haemoadsorber that contains human serum albumin immobilised on polymethacrylate beads. Trends in the improvement of morbidity and organ dysfunction were reported in initial non-randomised studies, although a subsequent multicentre RCT could not identify any significant clinical benefit, which then limited its clinical use. Currently, the MATISSE-Fresenius system is not available in Hong Kong.

**Alteco Lipopolysaccharide Adsorber**

The Alteco LPS Adsorber (Alteco Medical AB, Lund, Sweden) captures endotoxins using specifically designed synthetic peptides. This device was launched in 2006. Tailor-made synthetic peptides with a high affinity for endotoxins are attached to the surface of the polyethylene plates using a covalent bonding technique. Clinical experience with this device is scarce, and is limited mainly to case reports and case series. In general, these case series report a shorter vasopressor infusion duration in adsorber-treated patients compared with controls. Only one underpowered RCT has been published by local investigators. The study was terminated early and showed no significant clinical benefit (disease severity score, vasopressor use, length of study, and 28-day mortality) following the addition of the Alteco LPS Adsorber to conventional therapy.
in patients who had intra-abdominal sepsis with shock. The side-effect profile of this novel device was acceptable but a recent ex-vivo experimental study showed that the Alteco LPS Adsorber could not achieve acceptable LPS clearance in serum, heparinised plasma, or whole blood. Therefore, the potential benefit of the Alteco LPS Adsorber in sepsis is not clear.

**Cytokines haemadsorptive device**

Several cytokine-absorbing columns have been tested in animal studies, showing excellent adsorption rates for inflammatory cytokines such as TNF-α, IL-1β, IL-6, and IL-8. Human data are limited to case reports and case series. CytoSorb (CytoSorbents Corporation; Monmouth Junction [NJ], US) is a novel synthetic haemabsorption column that targets inflammatory mediators. It is currently the only European-approved extracorporeal device for cytokine haemadsorption. Case reports show good cytokine clearance and haemodynamic improvement with this device. Further studies focused on clinically relevant endpoints are highly recommended. CytoSorb is not available in Hong Kong.

**High-adsorption haemofiltration**

The AN69 and polymethylmethacrylate (PMMA) membrane haemofilters are the currently available options for performing high-adsorption haemofiltration in septic patients. Both have a high cytokine adsorption capacity but surface treatment can further modify their haemoadsorptive properties.

**oXiris haemofilter**

oXiris (Gambro Hospal, Stockholm, Sweden) is an AN69-based membrane haemofilter that is surface-treated with a polyethyleneimine and grafted with heparin (Table 2). The AN69 core membrane has superior cytokine-binding capacity compared with the traditional polysulphone membrane. Surface treatment with polyethyleneimine enhances endotoxin capture, while heparin coating reduces membrane thrombogenicity, and prolongs the filter life and improves efficiency. A case-control study by Shum et al involving Gram-negative septic patients (n=6) showed that oXiris continuous venovenous haemofiltration (CVVH) was associated with a greater reduction in Sequential Organ Failure Assessment score compared with conventional polysulphone-based CVVH (n=24). Subsequent large case series (n=40) suggested that oXiris treatment had a positive effect on haemodynamics with a reduction in cytokine levels (IL-6). Treatment usually lasts for 72 hours (manufacturer’s recommendation) and costs approximately HK$8000 per haemofilter. As of mid 2015, at least five public hospitals in Hong Kong have clinical experience with oXiris haemofilters in the treatment of septic shock. A large-scale RCT will be necessary to determine the potential benefit of this device, however.

**Polymethylmethacrylate haemofilter**

The PMMA membrane has a higher cytokine adsorption capacity than the traditional polycrylonitrile and polysulphone membrane. Membrane binding site saturation is one of the main concerns during treatment involving highly adsorptive haemofiltration. The PMMA haemofilter can maintain its cytokine adsorption capacity for at least 24 hours after being changed. The initial clinical experience of PMMA continuous haemodiafiltration in the treatment of sepsis is encouraging, with significant haemodynamic improvement and potential survival benefit. A local RCT (Australian New Zealand Clinical Trial Registry ACTRN12611000652976) that is aimed at investigating the clinical benefit of PMMA-based CVVH in patients with septic shock and AKI is currently underway. Treatment usually lasts for 24 to 48 hours and costs approximately HK$300 per haemofilter.

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**TABLE 2. Characteristics of locally available filters used in high cut-off haemodialysis, highly adsorptive haemofiltration, and plasmapheresis**

<table>
<thead>
<tr>
<th>Company</th>
<th>Filter name</th>
<th>Material</th>
<th>Therapy mode</th>
<th>Effective surface area (m²)</th>
<th>Cut-off (kDa)</th>
<th>Machine</th>
<th>Blood flow (mL/min)</th>
<th>Treatment time (hours)</th>
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<tbody>
<tr>
<td>FMC</td>
<td>EMiC 2</td>
<td>Polysulphone</td>
<td>CVVHD</td>
<td>1.8</td>
<td>40</td>
<td>Multifiltrate AK200US</td>
<td>100-350</td>
<td>72 (maximum)</td>
</tr>
<tr>
<td>Gambro/Baxter</td>
<td>septeX</td>
<td>PAES</td>
<td>CVVHD</td>
<td>1.1</td>
<td>45</td>
<td>Prismaflex</td>
<td>80-400</td>
<td>24 (maximum)</td>
</tr>
<tr>
<td>Gambro/Baxter</td>
<td>oXiris</td>
<td>AN69 ST</td>
<td>CVVH/CVVHDF</td>
<td>1.0</td>
<td>-20</td>
<td>Prismaflex</td>
<td>100-250</td>
<td>72 (maximum)</td>
</tr>
<tr>
<td>Toray</td>
<td>BG2.1U</td>
<td>PMMA</td>
<td>CVVH/CVVHDF</td>
<td>2.1</td>
<td>-20</td>
<td>Multifiltrate AK200US S008</td>
<td>150-350</td>
<td>24-48</td>
</tr>
<tr>
<td>FMC</td>
<td>PlasmaFlux</td>
<td>Polysulphone</td>
<td>Plasmapheresis</td>
<td>0.6</td>
<td>400-800</td>
<td>Multifiltrate</td>
<td>80-250</td>
<td>2-4</td>
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Abbreviations: CVVH = continuous venovenous haemofiltration; CVVHD = continuous venovenous haemodialysis; CVVHDF = continuous venovenous haemodiafiltration; FMC = Fresenius Medical Care; PAES = polyarylethersulphone; PMMA = polymethylmethacrylate
High-volume haemofiltration

In 2002, HVHF was defined as >35 mL/kg/h, based on recommendations from the Acute Dialysis Quality Initiative Workgroup. Nonetheless in clinical practice, 35 mL/kg/h is not that high and can be achieved with ease, especially in those with low body weight. To clarify this issue, Honore et al defined continuous HVHF as 50 to 70 mL/kg/h, and 100 to 120 mL/kg/h for 4 to 8 hours followed by conventional CVVH as pulse HVHF. In addition, HVHF is regarded as effective blood purification therapy because circulating inflammatory mediators are mostly water-soluble and range between 5 kDa and 60 kDa. They are more effectively removed by convective means than by diffusion techniques. Moreover, haemofilter membranes have some adsorptive properties that allow the removal of mediators with a molecular weight higher than the membrane cut-off point. It is clear that conventional haemofiltration with low ultrafiltration rates is ineffective for cytokine removal. Increasing the ultrafiltration flow rate can increase the adsorption capacity of the haemofilter because of its effect on transmembrane pressure (greater membrane site recruitment) and the exposure of more available adsorptive surface area. Only two RCTs that investigated the potential benefit of HVHF over conventional CVVH in septic patients were available before the publication of the landmark trial (high-volume versus standard-volume haemofiltration for septic shock patients with acute kidney injury study) in 2013. Cole et al performed the first randomised crossover clinical trial that involved 11 patients with septic shock and multi-organ failure. Patients were assigned to either 8 hours of HVHF (6 L/h) or 8 hours of standard CVVH (1 L/h) in a random order. The results showed that HVHF was associated with a greater reduction in vasopressor use. A study by Bousseskey et al (HVHF 65 mL/kg/h vs control 35 mL/kg/h; n=20) yielded similar findings and showed no survival benefit of HVHF over conventional CVVH. Multiple non-randomised studies showed decreased mortality with HVHF for septic shock patients but most of the studies were relatively small. Despite the initially encouraging results, HVHF has not gained in popularity because the use of a large volume of ultrapure replacement solution equates to significant increases in treatment cost, risk of severe electrolyte disturbance, and nursing workload. The landmark IVORIE study was published in 2013. This multicentre RCT involved 140 critically ill septic shock patients who were randomised to receive either HVHF at 70 mL/kg/h or standard CVVH treatment at 35 mL/kg/h. It showed neither significant survival benefit nor haemodynamic improvement for HVHF compared with standard treatment. Subsequently two meta-analyses (4 studies with approximately 500 patients) published in 2014 concluded that neither HVHF nor pulse HVHF offered any added clinical benefit when compared with standard-volume haemofiltration. Therefore, the routine use of HVHF for treatment of sepsis is not recommended.

High cut-off haemodialysis/ haemofiltration

Inflammatory mediators are relatively large (TNF-α: 17 kDa, IL-6: 26 kDa, and IL-8: 8 kDa), and are classified as middle molecules. The conventional high-flux haemofilter has a cut-off point at approximately 20 kDa and is unlikely to achieve good cytokine clearance. The nominal cut-off point for HCO membranes ranges from 60 to 150 kDa and the clinical cut-off point in blood ranges from 40 to 100 kDa. This can greatly increase the sieving coefficients of various inflammatory mediators at the expense of loss of albumin (66 kDa), antithrombin-III (60 kDa), protein C (62 kDa), and many other vital proteins. Reducing the pore size slightly can limit vital protein loss but also decrease cytokine removal. Ex-vivo studies showed that HCO haemofiltration displayed the greatest consistency in cytokine removal when compared with standard haemofiltration. The CPFA and haemoadsorption appeared to offer a similar level of cytokine clearance to the HCO technique. Albumin loss was comparable between HCO haemofiltration, HCO haemodialysis, and HCO haemodiafiltration. Morgera et al published the first study on the use of HCO haemofiltration among septic shock patients and showed good IL-6 (but not TNF-α) clearance. Subsequently, Morgera et al conducted an RCT that involved 30 septic AKI patients who were randomised to HCO or conventional haemofiltration. The HCO group showed a significant decline in vasopressor use and cytokine level. The largest RCT was the High Cut-Off Continuous Venovenous Hemodialysis (CVVHD) in Patients Treated for Acute Renal Failure After Systemic Inflammatory Response Syndrome (SIRS)/Septic Shock (HICOSS) study. The estimated sample size was 120 patients but the study was terminated early because of a lack of difference between the groups after 81 patients had been recruited. There was no difference in 28-day mortality, vasopressor use, duration of mechanical ventilation, length of stay in intensive care unit, or albumin level between the groups. This underpowered RCT (due to premature termination) cannot provide a clear answer about the potential benefit of HCO haemofiltration/haemodialysis in septic patients and a further large-scale prospective RCT is recommended. Only the septeX (Gambro Hospal, Stockholm, Sweden) and EMIC 2 (Fresenius SE, Bad Homburg, Germany) HCO haemofilters are available in Hong Kong (Table 2). Treatment usually lasts for 24 to 72 hours and costs approximately
Plasmapheresis and coupled plasma filtration adsorption

The nominal cut-off point for the plasma filter ranges from 400 to 800 kDa and therefore can achieve good cytokine removal with significant albumin loss (Table 2). Only three RCTs have been published to date. Busund et al70 published the largest RCT involving 106 adult septic patients randomised to receive either two sessions of plasmapheresis or standard therapy. Plasmapheresis offered better 28-day survival compared with the control group (67% vs 47%). Studies by Reeves et al71 and Long et al72 showed no survival benefit, however. Therefore, the debate regarding the benefit of plasmapheresis in sepsis continues. One important drawback of plasmapheresis is the significant loss of albumin, fibrinogen, antithrombin, and immunoglobulin that takes a long time to regenerate in the absence of post-treatment replacement.73 This problem can be resolved with the use of CPFA (Lynda, Belco, Mirandola, Italy). This CPFA therapy comprises a plasma filter, a non-selective hydrophobic resin cartridge with high affinity for inflammatory mediators, and a high-flux haemofilter for convective solute removal (Fig).74 Only filtrated plasma has direct contact with the sorbents that have no biocompatibility problems when compared with direct haemoperfusion. Treatment lasts for approximately 10 hours and requires cartridge changes due to saturation problems. Livigni et al75 published the only multicentre RCT focused on patients with septic shock. Patients were randomised to standard treatment with or without CPFA. The CPFA therapy was performed daily for 5 days and lasted at least 10 hours/day. The estimated sample size was 330 patients but the study was terminated early on the grounds of futility after 192 patients had been recruited. No significant benefits for mortality, organ dysfunction, or intensive care unit stay were observed. Therefore, based on the available evidence, the routine use of CPFA for treatment of septic shock is not recommended. The CPFA is currently not available in Hong Kong.

Conclusion

Building on the concept of excessive inflammatory mediator release, blood purification techniques have emerged as an adjunctive therapy for patients with severe sepsis and septic AKI. They are effective in clearing endotoxin or inflammatory mediators and are well tolerated. Despite initially promising results, most blood purification techniques have not provided any sustainable mortality benefits. In severe sepsis, source control, early appropriate antibiotics, and haemodynamic support are the three most important treatment components.76 As a supportive treatment, blood purification techniques may not significantly affect patient mortality. Since the outcome for septic patients has improved over time, much larger sample sizes will be needed to detect the relatively small effects of these new therapies on sepsis.77 Large-scale, well-designed, prospective RCTs are the way forward. The application of these novel techniques should be individualised but more specific recommendations must await further evidence.

Declaration of interests

All authors have disclosed no conflicts of interest.

References


45. Bouman CS, van Olden RW, Stoutenbeek CP. Cytokine filtration and adsorption during pre- and postdilution hemofiltration in four different membranes. Blood Purif
Extracorporeal blood purification for sepsis