Intravenous Milrinone in Cardiac Surgery

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Phosphodiesterase inhibitors including milrinone produce positive inotropic effects by slowing the hydrolysis of cyclic adenosine monophosphate in the myocardium. With a loading dose of 50 μg/kg followed by an infusion of 0.5 μg·kg⁻¹·min⁻¹, milrinone increases stroke volume index and left ventricular velocity of circumferential fiber shortening after weaning from cardiopulmonary bypass. Milrinone has potential for the treatment and prevention of internal mammary artery spasm because of its vasodilative effect, which is similar to that of papaverine, and is a potent pulmonary vasodilator for patients with right ventricular dysfunction and pulmonary vasoconstriction. Low-dose milrinone may have anti-inflammatory properties and potentially can improve splanchnic perfusion.

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Methods

A search of the MEDLINE database from 1975 to 2000 was conducted to identify pertinent articles using the keywords milrinone and cardiac surgery combined. The search was restricted to the English-language literature. The resulting articles were then further sorted to identify those most relevant to the topic. No specific criteria were used to make the final selection of the articles cited in this review, although every effort was made to recognize conflicting data and opinions.

Results

A total of 310 articles were identified that contained the combined search terms milrinone and cardiac surgery. From these 310 articles, the authors identified 42 that were deemed most relevant to cardiac surgery and used them as the basis for this review. An overview of the characteristics of milrinone and evidence of its use in cardiac surgery follows.

Characteristics and Use of Milrinone

Clinical Pharmacology

Compared with the catecholamines, milrinone has a longer half-time, necessitating a loading dose as well as a continuous infusion. During the first 12 hours of administration, drug disposition is determined largely by redistributional processes. As the length of administration increases, the effective half-time becomes more prolonged as tissue stores are saturated. The effective half-time is 36 minutes after 30 minutes of administration and increases to 138 minutes after 10 hours of administration [6]. For infusions lasting less than 10 hours, the half-time after discontinuation is less for milrinone than amrinone. The stability of milrinone has been demonstrated in the presence of 29 commonly used critical-care drugs and four intravenous solutions [7].

Milrinone has been shown to significantly increase cardiac index (CI) in patients with chronic CHF in a dose-related manner, with plasma concentrations ranging from 66 to 427 ng/mL. In cardiac surgical patients, Bailey and associates [4] reported that a milrinone loading dose of 50 μg/kg followed by a continuous infusion of 0.5 μg·kg⁻¹·min⁻¹ produced plasma milrinone concentrations in excess of 100 ng/mL and maintained thera-
peutic concentrations during weaning from cardiopulmonary bypass (CPB) and throughout the postoperative period. The plasma concentration associated with a 50% increase in CI was 167 ng/mL. The regimen of a 50–μg/kg loading dose plus an 0.5–μg·kg⁻¹·min⁻¹ infusion achieves plasma levels of 100 to 300 ng/mL, thus bracketing this concentration that will produce 50% of maximum response and exceeding the threshold for substantial hemodynamic effect.

**Clinical Effects**

In clinical trials, milrinone increased load-dependent indices of contractility (maximum rate of rise of left ventricular [LV] pressure) in a dose-dependent fashion in patients with CHF [9, 10]. In patients with CHF, milrinone was not shown to increase myocardial oxygen consumption [11]. Direct intracoronary infusions of 50 μg/min of milrinone in patients with severe CHF have been shown to enhance contractility, increase stroke volume, decrease LV end-diastolic pressure, and decrease heart rate [9]. In healthy volunteers, a 30– to 60–μg/kg loading dose of milrinone followed by maintenance infusions to obtain plasma levels of 81 to 261 ng/mL caused significant decreases in diastolic arterial pressure (−12%), mean arterial pressure (−11%), and LV end-diastolic dimension (−5%). In addition, significant increases in LV fractional shortening (+14%) were obtained [12]. Significant decreases in LV end-systolic dimension (−11%) and LV end-systolic wall stress (−32%) and a decrease in calculated systemic vascular resistance (−10%) were also observed. Contractility indices were linearly related to plasma milrinone concentrations. Milrinone produced a dose-dependent increase in the velocity of circumferential fiber shortening caused by decreased afterload and enhanced contractility.

In vascular smooth muscle, cAMP causes a decrease in intracellular calcium concentrations. In addition to its effect on the myocardium, milrinone causes smooth muscle relaxation and vasodilation. These effects result in decreases in mean arterial pressure, central venous pressure, and pulmonary artery occlusion pressure as well as increases in cardiac output (CO) owing to afterload reduction [3, 9–13]. It has been clearly demonstrated, using load-independent indices of cardiac function, that milrinone has a positive inotropic effect [12]. However, the increase in CO after milrinone administration may be as much due to afterload reduction as to increased inotropic state. The possibility of an increase in CO as the result of enhanced inotropic state and afterload reduction may be attenuated by decreased preload and, in a worst case scenario, coronary hypoperfusion owing to hypotension. Excessive vasodilatation may require fluid administration, vasopressors, or both. The vasodilating effects of milrinone have been shown to be dose dependent in patients with severe CHF [6].

Milrinone also affects diastolic function in patients with CHF, reducing diastolic pressure at any given diastolic volume while elevating maximum rate of rise of LV pressure (18%) and decreasing mean aortic pressure (11%) [13]. No changes occurred in peak LV systolic pressure. In addition, the peak LV filling rate increased by 42%, even though pulmonary artery occlusion pressure decreased.

**Use in Cardiac Surgical Patients After CPB**

Catecholamines are frequently administered to facilitate separation from CPB and to maintain an adequate CO postoperatively in the cardiac surgical patient. The mechanism of action of catecholamines is stimulation of cAMP production. Milrinone potentiates action of these agents by inhibiting the breakdown of cAMP. This may be particularly important in patients who were in CHF prior to operation, as β₁-adrenergic receptors can be down-regulated in this population. Therefore, when ventricular dysfunction occurs despite standard catecholamine therapy, milrinone can provide additional and effective inotropic support.

Milrinone has been shown to increase CI and improve hemodynamics in a variety of cardiac surgical and CHF patients. Feneck [14] studied 99 adult patients after elective cardiac operation who had a low CO (CI < 2.5 L·min⁻¹·m⁻²) with a pulmonary artery occlusion pressure of 8 mm Hg or higher. In this study, patients received a loading dose of milrinone (50 μg/kg over a 10-minute period) followed by a continuous infusion of one of three dosages—0.375, 0.5, or 0.75 μg·kg⁻¹·min⁻¹ (low-, middle-, and high-dose groups, respectively)—administered for a minimum of 12 hours. Patients were sequentially allocated to each dosage group. Hemodynamic measurements were made prior to therapy and up to 12 hours after the start of milrinone therapy. Milrinone treatment resulted in a rapid, well-sustained, and highly significant increase in CI in all three dosage groups and a similar reduction in pulmonary artery occlusion pressure in all groups. Significant reductions were also observed in systemic vascular resistance and pulmonary vascular resistance (PVR), although changes in the latter were less predictable and more dose dependent. Further analysis revealed that low CI (1.59 L·min⁻¹·m⁻²), high resting PVR (>200 dynes s cm⁻⁵), and low mean arterial pressure (64 mm Hg) prior to treatment were predictors of a good therapeutic response to milrinone [15].

Another placebo-controlled, double-blind study [16] demonstrated the benefits of milrinone in facilitating weaning of high-risk patients from CPB. Patients were randomized to receive either intravenous milrinone (50–μg/kg loading dose over 20 minutes followed by 0.5–μg·kg⁻¹·min⁻¹ infusion) or placebo 15 minutes before withdrawal from CPB. Of the 30 patients who completed the study, bypass support was withdrawn successfully in all 15 patients randomized to receive milrinone but in only 5 of the 15 patients randomized to receive placebo. The remaining 10 patients in the placebo group who were unable to be separated from CPB had milrinone administered in an open-label phase. After receiving milrinone treatment, these remaining patients were successfully withdrawn from CPB.

Using both standard hemodynamic measures and echocardiography, Kikura and coworkers [17] studied the effects of milrinone in cardiac surgical patients immediately after separation from CPB. The results of this study indicated that milrinone improved LV function and he-
modynamics in patients who were undergoing treatment with catecholamines, vasodilators, or both under constant loading conditions maintained by volume reinfusion from the CPB reservoir. All milrinone dosing regimens (50–µg/kg bolus only, 50–µg/kg bolus plus 0.5–µg·kg⁻¹·min⁻¹ infusion, and 75–µg/kg bolus plus 0.75–µg·kg⁻¹·min⁻¹ infusion) significantly increased CI, stroke volume index, and velocity of circumferential fiber shortening. After 5 and 10 minutes, these values were significantly higher in the milrinone groups than in the control group (Figs 1, 2). The increase in velocity of circumferential fiber shortening indicated a positive inotropic effect of milrinone in cardiac surgical patients.

This study confirmed the dose–response relationship previously demonstrated by Butterworth and colleagues [18]. These investigators found that in cardiac surgical patients, bolus doses of milrinone, 50 to 75 µg/kg, produce significantly larger increases in CI than a 25–µg/kg bolus dose immediately after separation from CPB. However, a dose of 75 µg/kg did not produce a significantly larger increase in CI than did a 50–µg/kg dose. This study indicates that a 50–µg/kg loading dose is more potent than a 25–µg/kg dose and as potent as a 75–µg/kg dose. Although the recommended loading dose for treatment of deteriorating ventricular function after separation from CPB is 50 µg/kg [18], a loading dose of 20 µg/kg followed by an infusion of 0.5 µg·kg⁻¹·min⁻¹ provides hemodynamic support similar to that observed with a loading dose of 40 µg/kg followed by an infusion of 0.5 µg·kg⁻¹·min⁻¹ in elective coronary artery surgical procedures [19].

Vascular Effects
Milrinone has a potent ability to reverse vasospasm in arterial grafts [20]. The pathophysiology of vasospasm in arterial grafts is complex and includes multiple factors, of which platelet activation and release of thromboxane A₂ may be the most important [21]. Reversing vasospasm is often challenging. Several studies [21, 22] have demonstrated the vasodilative effect of milrinone in internal mammary artery (IMA) rings harvested from patients undergoing coronary artery bypass grafting with IMA as bypass conduits. Salmenpera and Levy [20] reported the ability of PDE inhibitors in vitro to reverse the constriction of human IMA rings induced by a thromboxane A₂ analogue (U46619). Milrinone, amrinone, and enoximone each produced complete inhibition of the contractile response induced by U46619 in the IMA rings (Fig 3). Milrinone was the most potent inhibitor (0.3 ± 0.1 × 10⁻⁵ mol/L). The potency ratios of milrinone obtained for IMA vasodilation are compatible with the recommended clinical infusion doses [21]. In addition, these potency ratios are within range of the ratio of plasma milrinone concentrations that lead to a 50% increase in CI or ventricular
Venous, and hepatic venous oxygen saturations; intramus- 

The following variables were recorded: hemodynamics; arterial, mixed 

Paverine after precontraction with 10⁶ mol/L 

Mollhoff and colleagues [25] evaluated the effects of 

Antiin 

Hydrochloride, prostaglandin E1, and isradipine, a dihy-

different vasodilators that act through separate pathways 

Gamow and coworkers [22] investigated the effect of 

Huraux and coworkers [22] investigated the effect of 

Vasospasm of arterial grafts represents an unpredict-

Milrinone has little effect on cGMP, and it has been 

Milrinone has a larger volume of distribution and a 

cosal pH; and mixed and hepatic venous plasma concen-

contractility in patients with CHF and in cardiac surgical 

Vasospasm of arterial grafts represents an unpredict-

Use in Children 

Chang and associates [27] administered milrinone, 

contractility in patients with CHF and in cardiac surgical 

Vasospasm of arterial grafts represents an unpredict-

Milrinone has a larger volume of distribution and a 

Antiinflammatory Effects 

Mollhoff and colleagues [25] evaluated the effects of 

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Fig 3. Average concentration–response curves for inamrinone, enoximone, milrinone, and pa-

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the derived pharmacokinetic indicators suggest that an appropriate concentration can be achieved by administering a loading dose of 50 μg/kg followed by an infusion of approximately 3 μg·kg⁻¹·min⁻¹ for 30 minutes and a maintenance infusion [28].

Use in Orthotopic Heart Transplantation

Givertz and coworkers [29] reported the use of milrinone to test pulmonary vascular reactivity in patients with severe CHF before orthotopic heart transplantation. In 27 patients with functional class III or IV heart failure with a PVR of 200 dyne s cm⁻² or higher, a single milrinone dose (50 μg/kg) infused over 1 minute decreased PVR in all patients. The effect was maximal 5 to 10 minutes after the dose and persisted for at least 20 minutes. The mean decrease in PVR at 5 minutes (31% ± 4%) was associated with a 42% ± 4% increase in CO and decreases of 12% ± 4% and 16% ± 5% in mean pulmonary artery pressure and pulmonary artery occlusion pressure, respectively. No change in transpulmonary pressure gradient was demonstrated that short-term milrinone administration attenuates the potential for vasodilator-induced hypotension, and it has been used as a pulmonary vasodilator in patients undergoing orthotopic heart transplantation.

Sherry and Locke [31] used milrinone as a pharmacologic bridge to orthotopic heart transplantation by improving hemodynamic parameters in patients in whom the response to β agonists was inadequate. The condition of 1 patient with β agonist–resistant CHF and balloon counterpulsation was stabilized with milrinone for 21 days and subsequently was maintained with medical therapy until heart transplantation 3 months later. Stabilization of another 9 patients with severe compensated CHF was accomplished for between 11 and 51 days with milrinone. Seven of the patients received donor hearts, and 2 patients died before suitable organs could be found. All patients in the study demonstrated clinical improvement within 48 hours after treatment with milrinone was initiated.

Adverse Effects

Rapid milrinone administration produces high peak plasma levels, decreasing systemic vascular resistance and venous return and causing hypotension, especially in hypovolemic patients. Therefore, slower administration of milrinone over 10 minutes is recommended. Decreases in preload may require substantial volume loading. In addition, concomitant administration of α-adrenergic agents such as phenylephrine, norepinephrine, or dopamine hydrochloride attenuates the potential for vasodilation. When hypotension is refractory to norepinephrine, low-dose vasopressin therapy can be useful [32, 33].

Like all positive inotropic agents, milrinone has possible proarrhythmic effects. Oral milrinone did not receive approval from the Food and Drug Administration because of increased mortality compared with placebo and increased incidence of syncope, possibly attributable to proarrhythmic effects [34]. The major electrophysiologic effect of intravenously administered milrinone is enhanced atrioventricular node conduction [35]. However, increased ventricular ectopy can occur with short-term intravenous therapy [36].

Amrinone, the first PDE III inhibitor, that is now called inamrinone has been associated with thrombocytopenia during therapy [36–39]. The mechanism of inamrinone-induced thrombocytopenia is thought to be a nonimmunemediated toxic effect of inamrinone or its metabolite (N-acetyl amrinone) on megakaryocytes or platelets, resulting in decreased survival time of the platelet [38]. In platelets, cAMP generated from adenosine triphosphate by adenyly cyclase serves as an intracellular messenger to inhibit the platelet activation sequence at numerous steps [40]. Phosphodiesterase inhibitors can affect platelet aggregation in vitro [41]. However, compared with amrinone, milrinone does not seem to have an adverse effect on platelets. A study by Kikura and associates [42] demonstrated that short-term milrinone administration did not cause significant changes in platelet number or function in patients undergoing cardiac operations requiring CPB, beyond the usual adverse effects of a cardiac surgical procedure and CPB.

Comment

Milrinone is a selective inhibitor of the cAMP–specific phosphodiesterase III isoenzyme in myocardium and vascular smooth muscle. By increasing cAMP concentrations in both myocardium and vascular smooth muscle, milrinone causes an increase in CO through combined positive inotropic and vasodilative effects. Administration of milrinone is typically associated with a decrease in systemic blood pressure and cardiac filling pressures. This drug has been used effectively during separation from CPB and for the treatment of low CO syndrome after cardiac operations. Its pharmacokinetics are more prolonged than those of the catecholamines commonly used for inotropic support after cardiac surgical procedures. Administration requires both a loading dose and a continuous infusion.

Milrinone may be particularly efficacious in patients who are at risk for β-receptor down-regulation, such as those with CHF prior to operation. Milrinone may prevent or attenuate vasospasm of arterial conduits. It has been used effectively in the treatment of right ventricular failure, particularly after orthotopic heart transplantation.

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References

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