

SUPPLEMENTAL DIGITAL CONTENT

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SUPPLEMENTAL RESULTS

Figure 1. Proportion of cases having their lowest platelet count on each postoperative day.

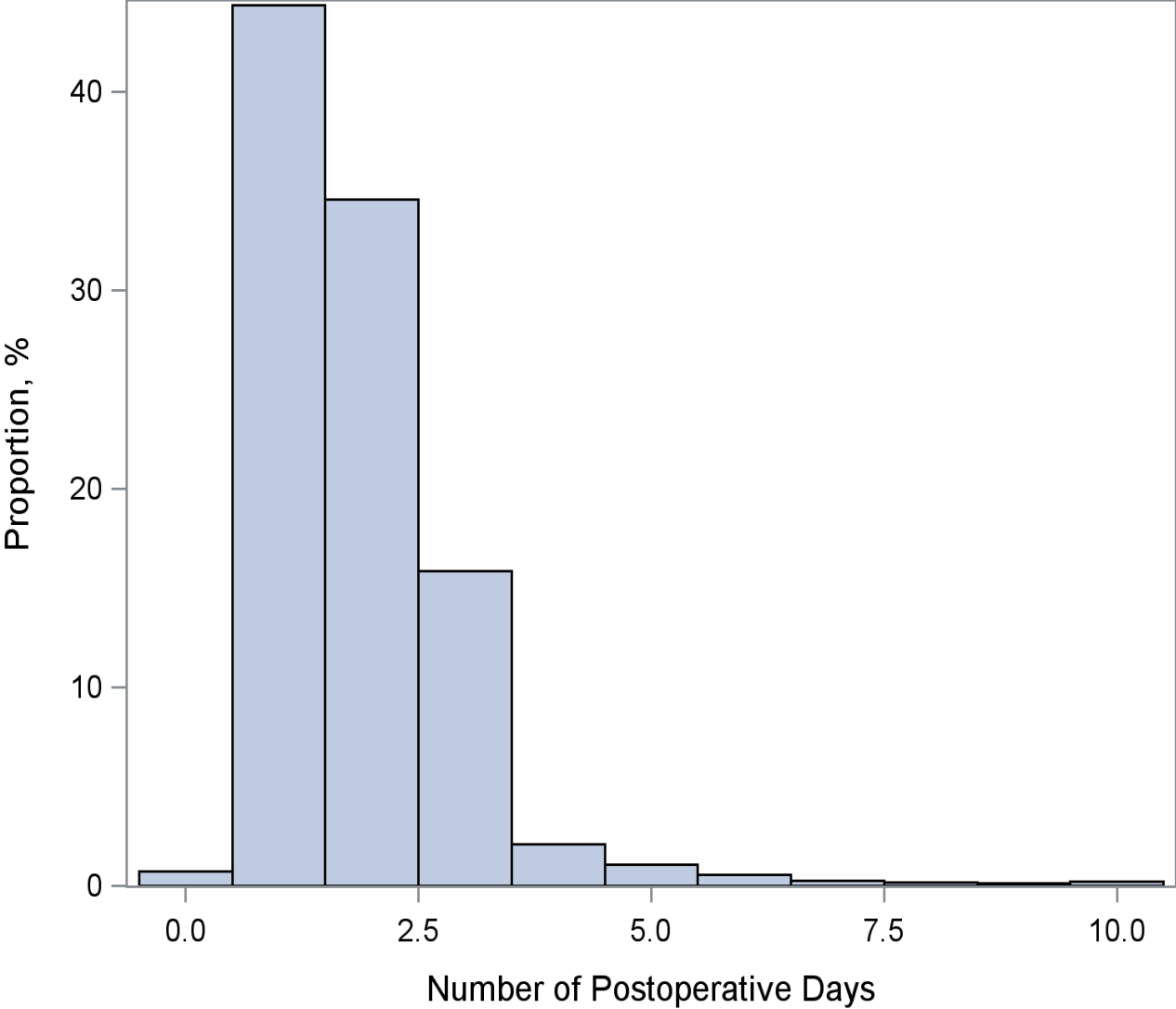


Figure 2. Association between postoperative nadir platelet counts and estimated risk for postoperative acute kidney injury (AKI). The black line represents the point estimates and their corresponding 95% confidence limits (shaded area) of the model-predicted probability of postoperative AKI. Risk estimation was based on a multivariable logistic model using the following clinical variables: age 64 years, male sex, white race, normal left ventricular function, no history of diabetes mellitus, no history of preoperative calcium-channel blocker use, no intraoperative use of aprotinin and nitroprusside, perioperative administration of red blood cell transfusions, preoperative serum creatinine concentration < 2 mg/dL, preoperative hemoglobin concentration equal to 13 g/dL, preoperative platelet count equal to $211 \times 10^9/L$, duration of cardiopulmonary bypass time of 118 minutes, and postoperative nadir hemoglobin concentration equal to 8.8 g/dL.

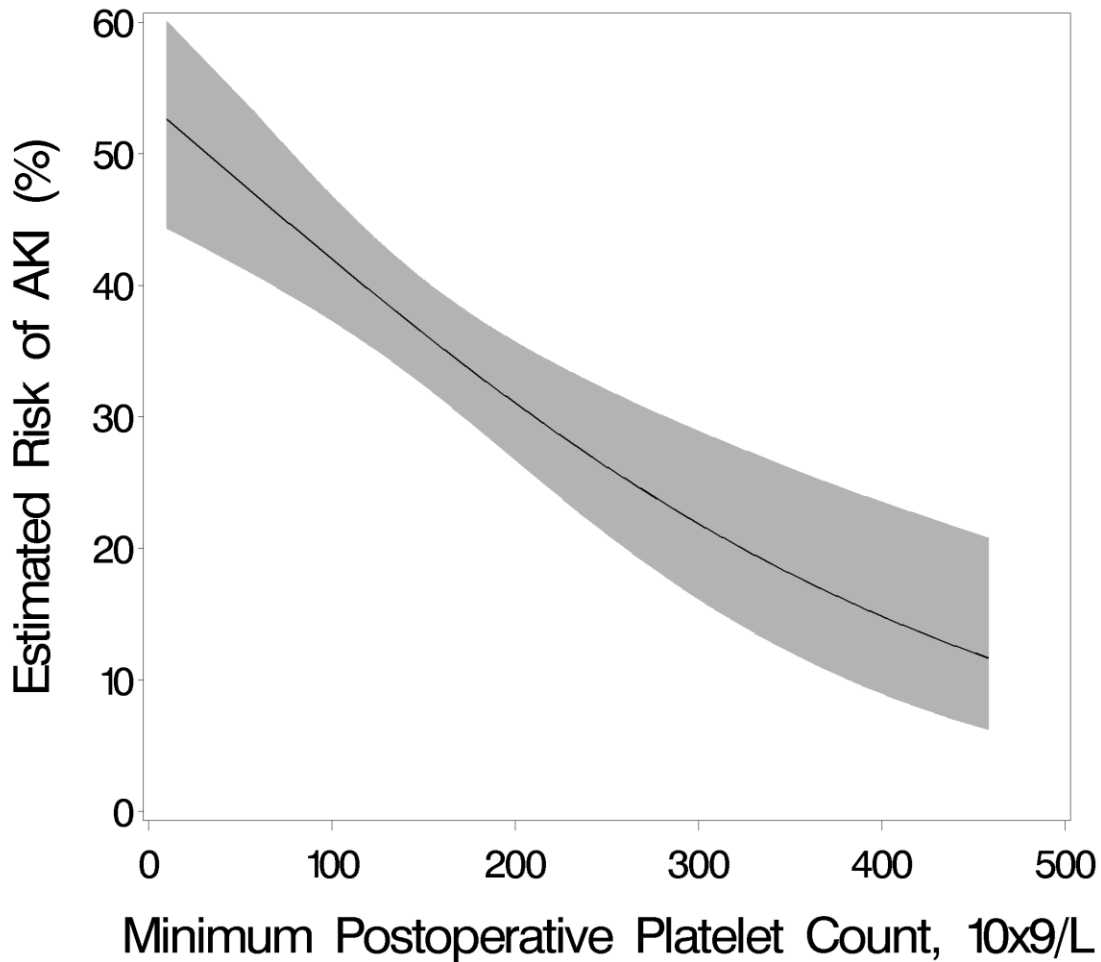


Figure 3. Residual plot demonstrating that the variable of postoperative thrombocytopenia defined as postoperative nadir platelet counts $\leq 74 \times 10^9/L$ violated the proportionality assumption. There was a linear decline of log hazard ratio (HR) until 1.17 years, and then a constant log HR for the remainder of follow-up.

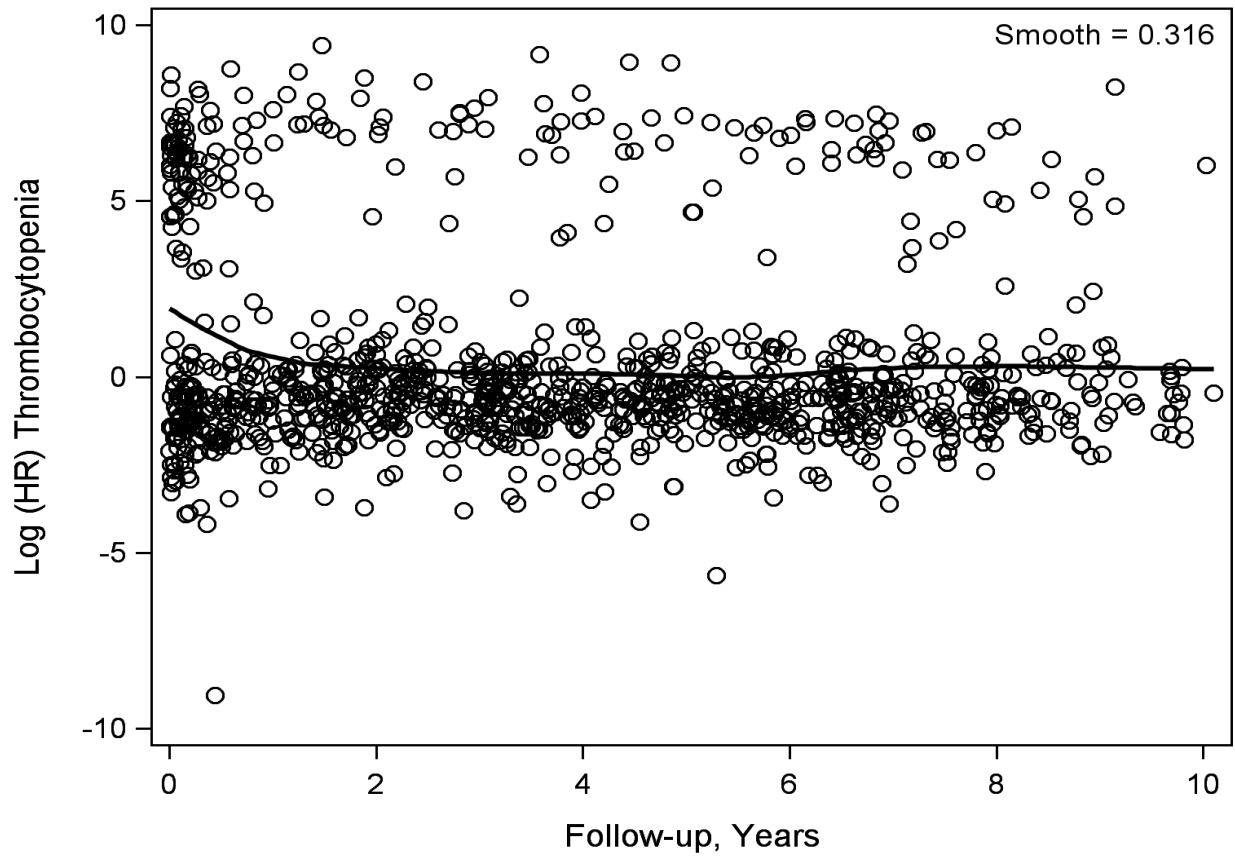


Figure 4. Residual plot demonstrating that the variable of postoperative acute kidney injury (AKI) violated the proportionality assumption. There was a linear decline of log hazard ratio (HR) until 1.51 years, and then a constant log HR for the remainder of follow-up.

