# Predicting Blood Transfusions for Coronary Artery Bypass Graft Patients using Deep Neural Networks and Synthetic Data

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## Abstract

Coronary Artery Bypass Graft (CABG) is a common cardiac surgery but continues to have many associated risks, including the need for blood transfusions. Previous research has shown that blood transfusion during CABG surgery is associated with an increased risk for infection and mortality. The current study aims to use modern techniques, such as deep neural networks and data synthesis, to develop models that can best predict the need for blood transfusion among CABG patients. Results show that neural networks with synthetic data generated by DataSynthesizer has the best performance. Implications of results and future directions were discussed.

**Keywords** deep neural network • data synthesis • blood transfusion • cardiac surgery

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## Introduction

Coronary Artery Bypass Graft (CABG) is a common cardiac surgery but continues to have many associated risks, including major bleeding which might need blood transfusion. Previous research has shown that blood transfusion during CABG surgery is associated with an increased risk for infection and mortality after surgery [1]. Specially, post-operative blood transfusion after CABG is associated with higher odds of readmission and heart failure within 30-days [2].

To lower the risk of mortality after surgery, there is a need to develop models that preoperatively predict which patients will need an intra-operative or post-operative blood transfusion. This will not only help to improve patient selection and patient education, but also physician preoperative awareness and perioperative guidelines for CABG patients. Therefore, the goal of this research is to explore modern data analysis techniques and find the models that can best make predictions, including synthetic data generation and deep neural networks.

## Related Work

Research have been conducted to investigate factors that can help to predict major bleeding [3] and the need for red blood cell transfusion after cardiac surgery [4]. In one of the studies [5] that is most relevant to the current research, the researchers employed machine learning models to predict perioperative allogeneic blood transfusion for cardiac patients. The best model (Random Forest) showed good performance (AUC ranged from .76 - .86), however, the study has several limitations. For example, the data was from a single adult cardiac surgery center in Austria with a relatively small sample size (N = 3,782), thus the results may not be generalizable to other samples with more diverse demographics or nationalities. Moreover, the studies only predicted allogeneic blood transfusion (i.e., transfusion of more than 10 units of packed red blood cells (pRBC)), while blood transfusion has been reported to be associated with many known risks regardless of volume. Lastly, the study only tested the basic machine learning models (e.g., tree-based models), and it is likely that the performance can be significantly improved using more advanced techniques and sophisticated models. For example, synthetic data generation techniques have been widely used to train and test neural networks, especially when the data has privacy concerns such as medical/clinical data [CITE].

To address this research gap, the current research used the national medical database in the U.S. with a large sample size of over 13,500 data points. Additionally, we predicted the need for blood transfusion regardless of volume. Lastly, we experimented with various modern data analytic approaches to optimize the performance, including synthetic data generation and deep neural networks.

## Solution and Methodology

### Data Source and Data Preprocessing

The data was downloaded from the Participant Use Data File (PUF) on the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP). In the current research, we focus on the data from 2015 to 2022, which has a total of 13,534 observations and 296 variables across eight datasets.

First, we built a data preprocessing pipeline to clean the raw data, including imputation (mean for numeric variables and most frequent values for categorical variables), standardization, and encoding (e.g., one-hot encoding for categorical variables). Secondly, preprocessed data was reshaped before entering each neural network. Among the 296 variables, 41 features were identified as most relevant to the current study. The target variable is Occurrences Bleeding Transfusions, which is a binary variable predicting whether the patient needs blood transfusion during or after surgery. The target can be further categorized into intraoperative vs. postoperative vs. no transfusion, therefore can be transformed into a 3-class variable when needed. With different analysis strategies, these features were entered into our models to predict the target variable, and we compared the performance with each other as well as with the benchmarks from previous research.

### Exploratory Data Analysis (EDA)

Among the 13,534 patients in the eight-year combined dataset, nearly 80% are male. The mean age is 65.73 with a standard deviation of 9.82. As for ethnicity composition (see Table 1), nearly half of the patients are white (48%) though over a third did not report their ethnicity (44%). Body Mass Index (BMI) were calculated based on HEIGHT and WEIGHT, indicating the signs of overweight with a mean BMI of 29.26 and a standard deviation of 5.76.

**Table 1** Ethnicity Composition of CABG Patients.

|  |  |
| --- | --- |
| Ethnicity | Counts |
| White | 6,488 |
| Unknown/Not Reported | 5,918 |
| Black or African American | 606 |
| Asian | 381 |
| Some Other Race | 60 |
| American Indian or Alaska Native | 38 |
| Native Hawaiian or Pacific Islander | 36 |
| Native Hawaiian or Other Pacific Islander | 7 |

Among all CABG patients, around half of the patients had blood transfusion (52.8%) and the other half did not (see Figure 1), therefore the binary target variable Bleeding Occurrence is balanced. If further broken down into intra- vs. postop-blood transfusion, we can see that most of the patients who received blood transfusion had it *during* the surgery (86.5%) and only 13.5% had blood transfusion *after* the surgery.

A graph of blue bars

Description automatically generated with medium confidence

**Fig. 1** Bleeding Occurrence Breakdown.

### Analysis Strategy

In this study, we aimed to employ two deep neural networks – Fully-Connected Neural Networks (FNN) and Convolutional Neural Networks (CNN) to predict the need for perioperative blood transfusions for CABG patients. Additionally, we used two approaches to generate synthetic data to train these neural networks – DataSynthesizer and REaLTabFormer (Realistic Relational and Tabular Data using Transformers). Data Synthesizer is based off Baysian Networks, which are probabilistic graphical models that represent probabilistic relationship between variables. While REaLTabFormer uses a sequence-to-sequence (Seq2Seq) model for generating synthetic relational datasets and uses GPT-2 for non-relational tabular data.

In each type of neural network, we designed different models (e.g., different number of layers, activation functions, loss functions, etc.) and tested them with the original dataset, then we re-ran the models with synthetic datasets from DataSynthesizer and REaLTabFormer and compared the results to see which combination yields the best performance.

## Results and Discussion

### Fully-Connected Neural Networks (FNNs)

In FNNs, we designed eight models varying in complexity (5-layer vs. 7-layer with more neurons), optimizers (SGD vs. Adam), output activation functions (sigmoid vs. softmax) and their corresponding loss functions (binary cross entropy vs. categorical cross entropy) to see which one(s) makes the best predictions. To evaluate the model performance, we looked at metrics across accuracy, f1 score, area under the curve (AUC), rooted mean squared error (rMSE). The best model(s) are determined jointly by f1 score and accuracy score with rMSE and AUC as supplementary benchmarks.

**4.1.1 FNNs with Original Data**

Results from FNN with the original dataset were shown in Table 2. Accuracy scores and f1 scores were landed in the range from .68 to .72, with a lowest rMSE of .46 and a highest AUC of .78. The best model was the five-layer design with SGD as optimizer and softmax as output activation function.

**Table 2** FNN results with original dataset.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Model | accuracy | f1\_score | rMSE | AUC |
| FNN-5layer-SGD-sigmoid | 0.7215 | 0.6888 | 0.4794 | 0.7764 |
| FNN-5layer-Adam-sigmoid | 0.7218 | 0.6961 | 0.4928 | 0.7756 |
| FNN-7layer-SGD-sigmoid | 0.7174 | 0.6954 | 0.4850 | 0.7741 |
| FNN-7layer-Adam-sigmoid | 0.7174 | 0.6782 | 0.5735 | 0.7752 |
| FNN-5layer-SGD-softmax | 0.7229 | 0.7200 | 0.4643 | 0.7782 |
| FNN-5layer-Adam-softmax | 0.7218 | 0.7179 | 0.4975 | 0.7815 |
| FNN-7layer-SGD-softmax | 0.7181 | 0.7150 | 0.4780 | 0.7780 |
| FNN-7layer-Adam-softmax | 0.7185 | 0.7118 | 0.5587 | 0.7766 |

**4.1.2 FNNs with Synthetic Data from REaLTabFormer**

The eight models showed slightly improved performance with the synthetic data from REaLTabFormer (see Table 3). The accuracy scores and f1 scores ranged from .72 to .74, with a lowest rMSE of .45 and a highest AUC of .80. The best models, once again, were the 5-layer model with SGD using either sigmoid or softmax function.

**Table 3** FNN results with synthetic dataset from REaLTabFormer.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Model | accuracy | f1\_score | rMSE | AUC |
| FNN-5layer-SGD-sigmoid | 0.7362 | 0.7420 | 0.4789 | 0.8006 |
| FNN-5layer-Adam-sigmoid | 0.7359 | 0.7394 | 0.4650 | 0.8007 |
| FNN-7layer-SGD-sigmoid | 0.7303 | 0.7392 | 0.4819 | 0.7939 |
| FNN-7layer-Adam-sigmoid | 0.7351 | 0.7315 | 0.5577 | 0.7972 |
| FNN-5layer-SGD-softmax | 0.7381 | 0.7380 | 0.4506 | 0.8008 |
| FNN-5layer-Adam-softmax | 0.7355 | 0.7355 | 0.4698 | 0.7999 |
| FNN-7layer-SGD-softmax | 0.7362 | 0.7362 | 0.4787 | 0.7995 |
| FNN-7layer-Adam-softmax | 0.7303 | 0.7286 | 0.5575 | 0.7934 |

**4.1.3 FNNs with Synthetic Data from DataSynthesizer**

Finally, results from FNN with the synthetic data from DataSynthesizer showed significantly improved performance (see Table 4). The accuracy scores and f1 scores ranged from .86 to .87, with a lowest rMSE of .42 and a highest AUC of .94. The best models were the 5-layer SGD model with sigmoid function and the 7-layer model SGD model with softmax function. However, although the 5-layer SGD model with sigmoid function had high accuracy and f1 score, its rMSE was the highest across all models across three datasets (rMSE = .67). An interesting observation was found with DataSynthesizer synthetic data that rMSE were relatively high with SGD optimizer across the board (rMSE =.55~.67) compared with same design with Adam optimizer (rMSE =.42~.45).

**Table 4** FNN results with synthetic dataset from DataSynthesizer.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Model | accuracy | f1\_score | rMSE | AUC |
| FNN-5layer-SGD-sigmoid | 0.8718 | 0.8776 | 0.6790 | 0.9386 |
| FNN-5layer-Adam-sigmoid | 0.8689 | 0.8772 | 0.4340 | 0.9474 |
| FNN-7layer-SGD-sigmoid | 0.8685 | 0.8774 | 0.5853 | 0.9358 |
| FNN-7layer-Adam-sigmoid | 0.8626 | 0.8712 | 0.4222 | 0.9456 |
| FNN-5layer-SGD-softmax | 0.8751 | 0.8749 | 0.6119 | 0.9421 |
| FNN-5layer-Adam-softmax | 0.8696 | 0.8696 | 0.4286 | 0.9495 |
| FNN-7layer-SGD-softmax | 0.8762 | 0.8762 | 0.5596 | 0.9401 |
| FNN-7layer-Adam-softmax | 0.8670 | 0.8667 | 0.4513 | 0.9474 |

### Convolutional Neural Networks (CNNs)

Sample\_text.

Sample\_text.

Sample\_text.

Sample\_text.

Sample\_text.

## Conclusion

The current research aimed to employ modern techniques to develop models that can best predict the need for blood transfusions among CABG patients. Deep neural networks combined with data synthesis techniques have shown to significantly improve model performance. In FNNs, regardless of model complexity and design, models trained with synthetic data generated from DataSynthesizer had best performance across the board, with f1 score and accuracy ranged from .86 to .87, with a lowest rMSE of .42 and a highest AUC of .94. Future research should look into different methodologies to generate synthetic data for training and developing models that can help inform guidelines for major, high-risk surgeries.

## References

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