Abstracts and Programme

EUROANAESTHESIA 2005

Annual Meeting of the European Society of Anaesthesiology

Vienna, Austria,
May 28–31, 2005
European Journal of Anaesthesiology

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Subscription information. European Journal of Anaesthesiology is published monthly (one volume per annum) and the subscription prices for 2005 are as follows. Institutional: £599.00 (Europe), $985.00 (USA and Canada) and £639.00 (Rest of the World); Personal: £130.00 (Europe), $217.00 (USA and Canada), £135.00 (Rest of the World), in all cases post-free. Subscribers in the following countries who are not VAT-registered must add VAT at the appropriate rate: Belgium (6% BTW), France (2.1% TVA), Germany (7% MWST), Spain (4% IVA), The Netherlands (6% BTW). Orders for current subscriptions and back issues should be sent to EJA Subscription Orders, Cambridge University Press, Edinburgh Building, Shaftesbury Road, Cambridge CB2 2RU, UK. E-mail: ejaeditorial@cambridge.org.

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The ESA encourages, in particular, non-native English speakers to submit abstracts for the Annual Meeting. Please write as simply as possible and avoid language mistakes. After submission, each blinded abstract will be judged by three reviewers. Accepted abstracts will be published in the European Journal of Anaesthesiology, only if they are presented at the Meeting. Please be sure that your abstract, particularly any graphs, can be read easily, taking into consideration that the size of the original material submitted will be reduced for publication. The use of images, graphs or illustrations in colour is not allowed. Non-adherence to these submission guidelines may be cause for rejection of abstracts submitted.

All abstracts must be submitted online via the ESA Website www.euroanesthesia.org

The submission module will be available to submitters from 1 November to 15 December 2005

• You will find all necessary information in the “How to write an abstract?” and “How to submit an abstract online?” sections, in the Annual Meetings (abstracts) part of the website, as well as in the Frequently Asked Questions section of the abstracts module.
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• Schedule of presentation of accepted abstracts and nomination to the Best Abstract Competition will also be advised through the ESA Website.

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When submitting your abstract, you will be prompted to accept the following conditions:

• The work in the abstract should not be presented at a large English-speaking meeting before the Euroanaesthesia 2006 Meeting, nor should the work appear in another form at that meeting.
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• Studies involving animal or human subjects must satisfy the requirements of the institution or organization of the authors regarding the use of human subjects or animals in research.
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<td>14AP1</td>
<td>A.704–711 181</td>
</tr>
<tr>
<td>Saturday May 28</td>
<td>15:15–16:45</td>
<td>14AP2</td>
<td>A.712–718 183</td>
</tr>
<tr>
<td>Sunday May 29</td>
<td>12:30–14:00</td>
<td>14AP3</td>
<td>A.719–727 185</td>
</tr>
<tr>
<td>Monday May 30</td>
<td>10:45–12:15</td>
<td>14AP4</td>
<td>A.728–736 188</td>
</tr>
<tr>
<td>Monday May 30</td>
<td>14:00–15:30</td>
<td>14AP5</td>
<td>A.737–742 190</td>
</tr>
<tr>
<td>Monday May 30</td>
<td>16:15–17:45</td>
<td>14AP6</td>
<td>A.743–748 192</td>
</tr>
</tbody>
</table>

### Subcommittee 15 – Education, research and presentation

<table>
<thead>
<tr>
<th>Date and Day</th>
<th>Time</th>
<th>Session</th>
<th>Abstracts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sunday May 29</td>
<td>12:30–14:00</td>
<td>15AP1</td>
<td>A.749–755 193</td>
</tr>
<tr>
<td>Sunday May 29</td>
<td>14:30–16:00</td>
<td>15AP2</td>
<td>A.758–762 195</td>
</tr>
</tbody>
</table>

### Subcommittee 17 – Patient safety

<table>
<thead>
<tr>
<th>Date and Day</th>
<th>Time</th>
<th>Session</th>
<th>Abstracts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday May 30</td>
<td>10:40–15:30</td>
<td>17AP1</td>
<td>A.763–770 197</td>
</tr>
<tr>
<td>Monday May 30</td>
<td>16:15–17:45</td>
<td>17AP2</td>
<td>A.771–775 199</td>
</tr>
</tbody>
</table>

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A-1
Effect of a protective-ventilation strategy on systemic inflammation after esophagectomy

P. Michelet, A. Roch, B. Djourno, I. Decamps, P. Thomas, J.P. Auffray
Département d’Anesthésie Réanimation, Hôpital Sainte Marguerite, Marseille, France

Background and Goal of Study: Esophagectomy is characterised by a marked postoperative inflammatory reaction. The mechanical ventilation (MV) including a prolonged period of one-lung ventilation (OLV) could influence the peri-operative systemic inflammatory response. The aim of this prospective, randomised study was to compare two ventilatory strategies on the systemic peri-operative pro-inflammatory response.

Materials and Methods: 50 patients undergoing a radical esophagectomy were randomly assigned into a conventional MV group [tidal volume of 9 ml · kg⁻¹ during two and one-lung ventilation, two end-expiratory pressure (PEEP)] or a protective MV group [tidal volume of 9 ml · kg⁻¹ during two-lung ventilation and 5 ml · kg⁻¹ during OLV, PEEP 5 cmH2O]. Successive arterial blood samples for IL-1β and IL-6 were taken after induction of anesthesia (Time A), 15 minutes after the end of abdominal time (Time B), two (Time C) and 18 hours (Time D) after the end of surgical procedure.

Results and Discussions: Data (Mean ± SD) are shown in the table.

<table>
<thead>
<tr>
<th>T</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>ANOVA</th>
<th>Time</th>
<th>Ventilation</th>
<th>Interaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>IL-1 pg/ml</td>
<td>CV 0.12 ± 0.04</td>
<td>0.33 ± 0.34</td>
<td>1.14 ± 0.89</td>
<td>0.54 ± 0.18</td>
<td>P &lt; 0.001</td>
<td>P &lt; 0.001</td>
<td>P &lt; 0.001</td>
<td>P &lt; 0.001</td>
</tr>
<tr>
<td>PV 0.14 ± 0.13</td>
<td>0.17 ± 0.13</td>
<td>0.39 ± 0.27</td>
<td>0.30 ± 0.21</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IL-6 pg/ml</td>
<td>CV 0</td>
<td>70 ± 85</td>
<td>341 ± 243</td>
<td>222 ± 280</td>
<td>P &lt; 0.001</td>
<td>P &lt; 0.002</td>
<td>P &lt; 0.001</td>
<td>P = 0.01</td>
</tr>
<tr>
<td>PV 0</td>
<td>30 ± 19</td>
<td>149 ± 74</td>
<td>114 ± 80</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Conventional ventilation (CV), protective ventilation (PV).

Conclusion(s): In patients undergoing esophagectomy, a protective ventilatory strategy lead to a decrease in peri-operative systemic pro-inflammatory response.

A-2
Hyperontic saline/hydroxy-ethyl starch infusion during CPR from out-of-hospital cardiac arrest: a randomized preclinical trial

H. Krep, B. Schaefer, R. Bender, M. Breil, U. Heister, A. Hoeft, M. Fischer
Department of Anesthesiology and Intensive Care, University Clinics of Bonn, Bonn, Germany

Background and Goal of Study: Resuscitation is a measure to reduce neurologic damage after CA. That the concept of osmotic volume expansion during CPR is an effective remedy to reduce neurologic damage after CA.

Results and Discussions: Data (Mean ± SD) are shown in the table.

Conclusion: Infusion of 2 ml/kg/10 min HyperHAES® during CPR is safe and might improve neurologic outcome after out-of-hospital CA. Improved neurologic outcome is presumably due to reduced postischemic cerebral reperfusion disturbances. A clinical multicenter study is required to prove that the concept of osmotic volume expansion during CPR is an effective measure to reduce neurologic damage after CA.

References:

A-3
Independent risk factors for postoperative shivering

L. Eberhart, F. Döderlein, P. Kranke, A. Torossian, H. Wulf, A. Morin
Department of Anaesthesiology and Critical Care, Philippus-University Marburg, Marburg, Germany

Background and Goal of Study: Postoperative shivering (PAS) is uncomfortable for patients and potentially risky (1). The aim of this observational trial was to identify independent risk factors for PAS after general anaesthesia (2).

Materials and Methods: The study was approved by the local ethics committee. Potential risk factors for PAS were recorded in 1,340 consecutive patients. Signs of shivering, peripheral and core temperature, and thermal comfort were recorded in the postanaesthestic care unit. The data were split into 2 datasets (n = 1000) and a validation (n = 340) dataset. The first was used to identify independent risk factors for PAS and to formulate a risk score using backward-elimination logistic regression analysis. The proposed model was subsequently tested for its discrimination and calibration properties using ROC-curve analysis and linear correlation between the predicted and the actual incidences of PAS in the validation group.

Results and Discussions: The incidence of PAS was 11.6%. There were three major risk factors: young age, endoprosthetic surgery, and core temperature. The risk score derived from this analysis had a reasonable discriminating power, with an area under the ROC-curve of 0.69 (95% CI: 0.60-0.78; P < 0.0001). Further the measure of the calibration curve (g = 0.69± 0.02, R² = 0.82; P = 0.05) indicated a good and statistically significant agreement between predicted and actual PAS incidence.

Conclusion: Postoperative shivering can be predicted with acceptable accuracy using the four risk factors identified in the present study. The presented model may serve as a clinical tool to help clinicians to rationally administer prophylactic anti-shivering drugs.

References:

A-4
Impact of omega-3 fatty acids on mortality and length of hospital stay in severely ill patients

Department of Anaesthesiology and Intensive Care Med, University Hospital Carl Gustav Carus, Dresden, Germany

Background and Goal of Study: The impact of omega-3 fatty acids, exerts immune-modulating and organ-protective effects, even after short term infusion in both postoperative and critically ill patients (1,2).

Materials and Methods: After approval by the institutional Ethic Review Board we evaluated the effect different doses of fish oil (FO) emulsion (Omegaven-Fresenius-Kabi) on the clinical course of severely ill patients. Primary study end point was survival, secondary endpoints were length of hospital stay and use of antibiotics, with respect to the primary diagnosis. 861 Patients who received total parenteral nutrition (TPN) for at least 3 days from 82 German hospitals were enrolled in this prospective multicenter trial. The cohort was divided into 5 groups according to the administered FO dose.

Results and Discussions: The patients of this survey were 62 ±17 years old (SAPS II 32 ±14). TPN including FO had most favourable effects on survival, infection rates and length of stay when administered in doses of 0.1-0.2 g/kg/d. Diagnosis-related optimum FO doses are given in fig. The dose/kg/d of FO had to 2 to 3 times higher impact on outcome parameters than the ratio of n3/n6 which is considered to be a major determinant of beneficial n3 effects in current literature.
Evidence Based Practice and Quality Assurance

A-7
Price information at point of use reduces anaesthetic drug costs
N.G. Smart, M. Sim, D.A. Varveris, C.P. Gardiner
Department of Anaesthetics, Glasgow Royal Infirmary, Glasgow, United Kingdom

Background and Goal of Study: Some drugs used by anaesthetists are very expensive and greatly increase the cost of anaesthesia. Previous studies suggest cost awareness is limited (1, 2). The aim of this study was to determine whether making drug prices available at point of use reduces costs.

Materials and Methods: In a 16 week prospective study, price information was supplied by 2 methods. A price gun was used to attach price stickers to the drug packaging. Price lists were also displayed on the theatre drug cupboard showing expensive drugs and cheaper alternatives. There were 2 equal measurement periods: a control period of drug use without cost information and a study period with cost information. Drug use was tracked by ascribe drug inventory system. A theatre book audit established

Evidence Based Practice and Quality Assurance

A-5
Modifying the baricity of local anaesthetics for spinal anaesthesia by temperature adjustment – model calculations
A.R. Heller, K. Zimmermann, K. Seele, T. Rösse, E. Koch, R.J. Litz
Department of Anaesthesiology, University Hospital Dresden, Dresden, Germany

Background and Goal of Study: The baricity of local anaesthetics (LA) in relation to cerebrospinal fluid (CSF) determines LA distribution in the subarachnoid space (SAS). While LA are hyper- or isobaric at room temperature, baricity of CSF of patients undergoing SPA (n = 1100) was measured using a high precision densiometer (DMA 450 Paar, Graz, Austria, precision 0.00001 g/ml, 0.00001°C). Temperature was adjusted to 5, 20, 30, and 37°C. The density of aqueous solutions such as LA behaves in a temperature dependent non-linear manner which can be described by a 3rd degree polynomial equation. For clinical purpose, however, consideration of a simple quadratic equation is as applicable concerning precision (p < 0.0005; n = 0.999).

Results: are depicted in the table below.

<table>
<thead>
<tr>
<th>Density 20°C [g/ml]</th>
<th>Density 37°C [g/ml]</th>
<th>Density-equation (T = temperature [°C])</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 1.005764 ± 0.000240</td>
<td>0.999564 ± 0.000167</td>
<td>1.008–5.29*10⁻⁶°F</td>
</tr>
<tr>
<td>B 1.005259 ± 0.000028</td>
<td>1.001012 ± 0.000028</td>
<td>1.007–5.28*10⁻⁶°F</td>
</tr>
<tr>
<td>C 1.004598 ± 0.000464</td>
<td>0.999562 ± 0.000042</td>
<td>1.008–5.34*10⁻⁶°F</td>
</tr>
<tr>
<td>D 1.006170 ± 0.00000017</td>
<td>1.001011 ± 0.000177</td>
<td>1.008–5.35*10⁻⁶°F</td>
</tr>
</tbody>
</table>

Density of CSF was 1.000664 ± 0.000086 g/ml. Mathematical conversion of the calculated equation enables determination of the temperature in °C at which LA are isobaric (A) 35.08357; (B) 37.02509; (C) 35.08357; (D) 39.38902. Conclusion: Baricity of CSF is just one of the factors affecting the cranial extent during SPA. Thus, the clinical impact of our findings e.g. on hemo-dynamic stability must be confirmed in clinical studies.

A-6
Functional imaging of the visual cortex during wakefulness and during intravenous anaesthesia
Department of Anaesthesiology, University of Cologne, Cologne, Germany

Background and Goal of Study: Previous studies in primates and humans found a strong and reproducible visually induced functional magnetic resonance imaging (fMRI) signal in the visual cortex during mild isoflurane anaesthesia. Accordingly, we hypothesized that visual stimulation might also activate the human visual cortex during intravenous anaesthesia. The aim of this study was to assess the effect of propofol/remifentanil anaesthesia on visual-evoked activation of the visual cortex using fMRI-technique.

Materials and Methods: We studied four volunteers during wakefulness and eight patients during deep surgical anaesthesia maintained with propofol/remifentanil. For visual stimulation a binocular flash stimulus (1.7 Hz) was presented as a block design composed of 8 stimulation periods alternating with resting periods defined by the absence of the experimental stimulus with both periods lasting 25 s. Visual processing was analysed using cross-correlation analysis (r > 0.4; P < 0.0001, uncorrected). For data analysis the fMRI software tool BrainVoyager 2000 was used. Results and Discussions: Mean propofol plasma target concentration was 4.21 ± 0.64 µg/ml and mean rate of remifentanil infusion was 0.31 ± 0.09 µg/kg/min during fMRI data acquisition. Binocular visual stimulation during wakefulness as well as during propofol/remifentanil anaesthesia produced a significant activation in the visual cortex including the striate (Brodman’s area (BA 17)) and the extrastriate visual cortex (BA 18, 19). The finding of activated areas in the anaesthetised brain indicates that the underlying mechanism of the fMRI signal is preserved during surgical concentrations of propofol and remifentanil.

Conclusions: (1) This study demonstrates that early visual information processing is preserved during general anaesthesia induced by the intravenous anaesthetics propofol and remifentanil. (2) The fMRI method may be appropriate for further investigating the effect of different anaesthetics on various neuronal networks.

Acknowledgements: This study was funded by KÖLN FORTUNE, 66/2001.
activity (number of cases performed and total anaesthetic time). Weekly replicates of data were recorded to allow statistical analysis. Results calculated as mean cost in £ sterling (±SD) and compared with unpaired tailed Student’s t test (p < 0.05 significant).

Results and Discussions: Cost information led to a reduction in volatile costs of 40% with a decrease in sevoflurane and an increase in isoflurane and desflurane use (Table 1). This is consistent with migration from the expensive drug to cheaper alternatives. There was no change in the use of propofol for infusion. Remifentanil cost reduced by almost 25% with no change in fentanyl and morphine use. No significant difference in theatre activity was demonstrated between the study periods.

Table 1. Results presented as mean cost per week (£).

<table>
<thead>
<tr>
<th>Drug</th>
<th>Control period mean (±SD)</th>
<th>Study period mean (±SD)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sevoflurane</td>
<td>740(110)</td>
<td>357(46)</td>
<td>0.01</td>
</tr>
<tr>
<td>Desflurane</td>
<td>54(6)</td>
<td>95(13)</td>
<td>0.032</td>
</tr>
<tr>
<td>Isoflurane</td>
<td>13.5(3.8)</td>
<td>26.9(4.2)</td>
<td>0.026</td>
</tr>
<tr>
<td>Remifentanil</td>
<td>270.5(23)</td>
<td>193.9(25)</td>
<td>0.038</td>
</tr>
<tr>
<td>Morphine</td>
<td>26.25(7.1)</td>
<td>20.5(3.9)</td>
<td>0.59</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>25.25(4.7)</td>
<td>26.13(6.7)</td>
<td>0.98</td>
</tr>
</tbody>
</table>

Conclusion(s): A change in drug use patterns in response to cost information and a consequent reduction in drug spend is demonstrated.

References:

A-8

Awareness of drug costs in anaesthetic practice

C.P. Gardiner, M. Sim, D.A. Varveris, N.G. Smart
Department of Anaesthesia and Pain Management, Glasgow Royal Infirmary, Glasgow, United Kingdom

Background and Goal of Study: Anaesthetists must continually assess their choices in a cost containment environment. To make cost conscious decisions, the cost of each drug and its alternatives must be known but this knowledge may be lacking (2,3). This study examines cost awareness in a UK anaesthetics department.

Materials and Methods: 20 trainees and 30 consultants were asked by questionnaire to estimate the net price of 10 commonly used drugs. Estimated and true costs were compared thus: % difference of correct cost = (estimate – true cost)/true cost × 100.

Data presented as medians and ranges. Estimates for the 2 groups compared with Kruskal Wallis test (p < 0.05 significant).

Results and Discussions: Response rate was 84%. 39% of estimates were within 50% of the true price and 67% within 100%. Costs of some relatively expensive drugs such as sevoflurane were underestimated while less costly drugs like isoflurane were overestimated (see Table). Choice may depend on the perceived cost difference between drugs. Overestimation of the cost of a cheaper drug may then be important, especially if the price of the more expensive drug is at the same time underestimated.

Conclusion(s): Significant errors in cost estimations were observed. Overall this study shows that cost awareness is lacking among anaesthetists in a UK hospital setting.

References:

A-9

The contribution of nonsurgical time to session time depends strongly on total session time

F. Boer
OK Centrum, J-4-Q, Leiden University Medical Centre, Leiden, The Netherlands

Background and Goal of Study: Reducing the time needed for induction of and emergence from anaesthesia and the turnover time between patients is considered an important factor for improving efficiency and productivity. Thus the ratio of surgical time (OP) to session time (OR) should be high. Since we assumed that the contribution of nonsurgical time to session time decreases with increases in surgical time, we studied the dependence of the OP/OR ratio on case length.

Materials and Methods: Throughout times were calculated of 8650 sessions undergoing surgery under anaesthesia (general or regional) in a university medical centre. Session times (OR), surgical times (OP) and the ratio OP/OR were calculated for each case. The relationship between the OP/OR ratio versus OR was modelled with the equation OP/ORease = OR1/OR1 + MOR1 where MOR is the mean session time and γ a power value describing the steepness of the curve.

Results and Discussions: 31% of the OP/OR ratio’s were 0.5 of less and 11% of these ratio’s were higher than 0.8. There was a strong correlation between OR and OP (r2 = 0.938). The OP/OR ratio was strongly dependent on OR (r2 = 0.783). On average, if the OR is >0.28 h the OP/OR will be >0.5.

Conclusion(s): Improving OR efficiency by shortening nonsurgical time is relevant only if nonsurgical times have a significant contribution to session times. With the operating mix of a university hospital session times are long and OP/OR ratio’s largely >0.5. In these cases efficiency measures should target surgical efficiency.

A-10

Utilization of allocated block time: analysis of different factors

E. Bombaci, S. Colakoglu, A. Orskiran, B. Cevik, H. Buyukkilic, G. Berkel Yildirim
Department of Anaesthesiology and Intensive care, Dr. Lutfi Kirdar Kartal Education and Research Hos, Istanbul, Turkey

Background and Goal of Study: Allocation of block time and first starting times in operating rooms (OR) is a major challenge for OR managers and anaesthesiologists (1). The aim of this study was to determine the utilization of allocated block OR time by surgical services with the inclusion of turnover time (TT).

Materials and Methods: Data were collected prospectively from OR schedule of five different surgical services between February 1, 2004 and March 31, 2004. Workday hours were identified from 8:00 AM to 4:00 PM (Monday through Friday) for forty days. Definitions of terminology are listed.

Conclusion(s): Significant errors in cost estimations were observed. Overall this study shows that cost awareness is lacking among anaesthetists in a UK hospital setting.

References:
A-11
Intraoperative event: a predictive indicator of post anesthesia care unit jam?

E. Lambert, Y. Auray, S. Ausset, E. Batjom, A. Gnaho, B. Lenoir
Department of Anaesthesiology and Intensive Care, Percy Hospital, Clamart, France

Background and Goal of Study: The systematic collection and analysis of incidents is essential for risk management, but conseques of intraoperative events are often difficult to assess. Do they influence Post Anesthesia Care Unit (PACU) length of stay (LoS)?

Materials and Methods: From 01/2000 to 04/2004, every anesthesia is described with the patient features, the anesthetic technique and the occurrence of events (out of a list of 58), using a preformatted sheet then recorded in a data base. An univariate, then multivariate analysis were performed to assess associations between the occurrence of an intraoperative event and PACU LoS in Quartile (Q), taking into account age (Q), ASA physical status, surgery duration (Q), transfusion need, anesthetic technique.

Results and Discussions: All the anesthesia procedures have been analyzed (n = 19118), 22% are associated with incidents. PACU LoS is respectively 141 ± 100 min and 102 ± 110 min according to the occurrence of an incident or not (p < 0.05). As expected, patients who experience an intraoperative incident are older (53 ± 37 vs 46 ± 23) and suffer from a worse condition (ASA status) (p < 0.05). Odds ratio (OR) of associated factors are:

<table>
<thead>
<tr>
<th>Incident associated factors</th>
<th>OR CI 95%</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pacu [70–100] min (vs &lt;70)</td>
<td>2.2 [1.9–2.5]</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Pacu [100–135] min (vs &lt;70)</td>
<td>2.3 [2.6–3.5]</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Pacu &gt; 135 min (vs &lt;70)</td>
<td>3.0 [1.5–2.0]</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Age [30–45] (vs &lt;30)</td>
<td>1.1 [1.0–1.2]</td>
<td>NS</td>
</tr>
<tr>
<td>Age [46–64] (vs &lt;30)</td>
<td>2.4 [2.1–2.7]</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Age [65–89] (vs &lt;30)</td>
<td>3.2 [2.8–3.7]</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>ASA 2 (vs ASA 1)</td>
<td>1.1 [1.0–1.2]</td>
<td>NS</td>
</tr>
<tr>
<td>ASA 3 (vs ASA 1)</td>
<td>1.3 [1.1–1.5]</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>ASA 4–5 (vs ASA 1)</td>
<td>1.5 [1.2–2.2]</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Surg [50–90] min (vs &lt;50)</td>
<td>1.8 [1.5–2.0]</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Surg [90–145] min (vs &lt;50)</td>
<td>2.3 [2.0–2.6]</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Surg &gt; 145 min (vs &lt;50)</td>
<td>3.6 [3.1–4.1]</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Transfusion yes (vs no)</td>
<td>1.2 [0.9–1.6]</td>
<td>NS</td>
</tr>
<tr>
<td>GA (vs RA)</td>
<td>1.3 [1.1–1.4]</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

Conclusion: As a conclusion, turnover time can be reduced by improving the hospital and personal equipment. On the other hand type of surgery and anesthetic management are the other factors that affect the OR utilization.

Reference:

A-13
Cost-effectiveness of neuromuscular blocking agents
S. Morrone, G. Iohom, P. Dubois
Department of Anaesthesia and Intensive Care Medicine, CHU Nancy, Nancy, France

Background and Goal of Study: Neuromuscular blocking agents (NMBA) represent a major component of anaesthesia costs (1). The aim of this study was to investigate the cost-effectiveness of commonly used NMBA administered as equipotent bolus or infusions.

Materials and Methods: Eighty ASA III patients undergoing thoracic surgery were randomly selected to receive atracurium, cisatracurium, mivacurium or rocuronium. The neuromuscular block was monitored by accelerography. During propofol and sufentanil induction 2 × ED50 was administered as a bolus. This was followed by a potency-adjusted infusion targeted towards maintaining the first twitch at 15 ± 5% of control until chest closure. Bolus and infusion costs were compared taking into account the number of entire vials used. Results are expressed as mean ± SD.

Results and Discussions: Groups were similar with regards to age (65 ± 10 yrs), weight (74 ± 13 kg), renal and hepatic function. For tracheal intubation of patients weighing up to 125 kg, mivacurium was the most cost-effective. For infusions lasting up to 1.72 hrs, mivacurium was the cheapest. The second best place was shared by atracurium (from 1.72 to 2.39 hrs and from 4.12 to 7.17 hrs) and cisatracurium (from 2.39 to 4.12 hrs and 7.17 to 8.24 hrs).

Table 1. Data of surgical clinics in respect of OR utilization.

<table>
<thead>
<tr>
<th>Clinics</th>
<th>No of cases</th>
<th>TCD (min)</th>
<th>TTD (min)</th>
<th>TT (min)</th>
<th>AT (min)</th>
<th>Ratio of TT/TCD (%)</th>
<th>Ratio of TT/1200 min (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>136</td>
<td>17270</td>
<td>18620</td>
<td>1400</td>
<td>1215</td>
<td>7.49</td>
<td>7.20</td>
</tr>
<tr>
<td>B</td>
<td>162</td>
<td>15136</td>
<td>17505</td>
<td>2363</td>
<td>1330</td>
<td>13.49</td>
<td>12.30</td>
</tr>
<tr>
<td>C</td>
<td>155</td>
<td>18265</td>
<td>20645</td>
<td>2380</td>
<td>1155</td>
<td>11.55</td>
<td>12.39</td>
</tr>
<tr>
<td>D</td>
<td>132</td>
<td>13495</td>
<td>16505</td>
<td>3010</td>
<td>1405</td>
<td>18.23</td>
<td>15.60</td>
</tr>
<tr>
<td>E</td>
<td>133</td>
<td>15420</td>
<td>17590</td>
<td>2670</td>
<td>1560</td>
<td>15.17</td>
<td>11.30</td>
</tr>
</tbody>
</table>

Conclusion(s): The findings of this prospective, randomized, double blind study suggest that mivacurium is the most cost-effective NMBA for both tracheal intubation and continuous infusions lasting up to 1.72 hr.

Reference:

A-14
A quantitative systematic review on supplemental perioperative oxygen to reduce the incidence of postoperative nausea and vomiting
P. Kranke, A. Morin, C. Apfel, U. Schwemmer, N. Roewer, L. Eberhart
Department of Anaesthesiology, University of Würzburg, Würzburg, Germany

Background and Goal of Study: Supplemental oxygen has been shown to decrease the incidence of postoperative nausea and/or vomiting (PONV). In order to estimate the efficacy of an increased (~80%) oxygen concentration versus routine oxygen administration (~30%) administered in the perioperative period we performed a quantitative systematic review.

Materials and Methods: Systematic search (MEDLINE, EMBASE, CENTRAL, bibliographies, all languages, up to October 2004) for randomised comparisons of supplemental oxygen versus routine oxygen in surgical patients. Relevant outcomes were the incidences of postoperative nausea (PN), postoperative vomiting (PV) and PONV. We performed a sensitivity analysis. Reference trials were identified using relative risk (RR) with 95% confidence intervals (CI) calculated with a random effects model.

Results and Discussions: In 7 trials 742 patients received supplemental oxygen with 50–80% oxygen, balance nitrogen and 752 patients routine oxygen with 30% oxygen, balance nitrogen. These regimens were administered in the perioperative period and were maintained up to 2 hours in the postoperative period. Pooled RR for PN, PV and PONV with supplemental oxygen versus routine oxygen were 0.91 (95%-CI: 0.73–1.15), 0.78 (95%-CI: 0.62–0.98) and 0.90 (95%-CI: 0.71–1.15), respectively. RR for rescue treatment was 0.88 (95%-CI: 0.66–1.19). Due to considerable heterogeneity (I² Test ~ 70% for outcome “PONV”) we performed a sensitivity analysis. The marginal effect on PV depends on the inclusion of 2 initial trials that were performed in patients undergoing abdominal surgery and gynecologic laparoscopy. Restricting the analysis to the remaining 5 trials with a total of 1.104 patients revealed RR for PN, PV and PONV of 0.59 (95%-CI: 0.95–1.23), 0.86 (95%-CI: 0.67–1.09) and 1.09 (95%-CI: 0.86–1.32).

Conclusion(s): In accordance with the IMPACT study (1) the perioperative administration of supplemental oxygen in order to decrease the incidence of...
PONV cannot be regarded as valid concept so far. Potential effects in abdominal surgery need further analyses.

Reference:

A-15
Comparative study between two different anesthetic techniques in living related hepatectomy
M. Rabie, H. Negmii, H. Khalaf, H. Al Oufi
Department of Anesthesiology, MBC 22, King Faisal Specialist Hospital & Research center, Riyadh, Saudi Arabia

Background: Living donor hepatectomy (LDH) is now widely used to meet the need for liver grafts due to the shortage of cadaveric donors. Donor safety and perioperative anesthetic management are our major concern; the aim of our study was to compare two anesthetic techniques for management of living donor hepatectomy.

Patients and Methods: After ethical committee approval and informed written consent, 20 donors ASA I physical status undergoing hepatectomy for living related liver transplant were allocated randomly to one of two groups. Group A where anesthesia was induced with fentanyl 2 μg/kg and propofol 2–3 mg/kg, and maintained with isoflurane 0.8–1.2% and fentanyl infusion 1–2 mcg·kg⁻¹·h⁻¹. In group B anesthesia was induced with sufactant 0.2 mcg·kg⁻¹·min⁻¹, and propofol 2–3 mcg·kg⁻¹·min⁻¹, and maintained with propofol infusion 6–12 mg·kg⁻¹·h⁻¹ and sufactant infusion 0.2–0.4 mcg·kg⁻¹·h⁻¹. Atracurium was the muscle relaxant for intubation and maintenance in both groups.

Results: There were no perioperative mortality in both groups, no significant statistical differences between both groups as regard demographic data, duration of operation, hospital stay, intraoperative hemodynamics, blood loss, liver function tests (PT, AST, & ALT) measured in the first, third, and seventh days postoperative.

Conclusion: This study showed that both anesthetic techniques are comparable and well tolerated by the patients undergoing hepatectomy, and the most important is the overall perioperative hemodynamic & fluid management together with postoperative pain management.

A-16
Media disclosed sentinel events anaesthesiologist's views
S. Parente, R. Loureiro
Department of Anaesthesiology, 1S. Francisco Xavier Hospital & Council for Oual, Oeiras, Portugal

Background and Goal of Study: A growing number of sentinel events have been disclosed to the media. “A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof” Some of the disclosed cases have direct involvement of anaesthesiologists. How did anaesthesiologists view the impact of those events.

Materials and Methods: Survey of media published sentinel events from 2000 to July 2004. Interviews with over 6.5% of the registered anaesthesiologists.

Results and Discussions: Demographical data of the patients did not significantly differ. There were no significant differences in duration of surgery or use of anaesthetics. Average APFEL Score in group I and II were 2.9 ± 0.9 and 3.1 ± 0.7, respectively. Incidence of PONV in group I was 52%. Incidence of PONV in group II was 61%.

Conclusion(s): Incidence of PONV in both groups was high but reflected the expected incidence calculated by the APFEL Score. Preoperative fasting time does not seem to influence the incidence of PONV. There has been hope that a reduced residual gastric volume achieved through drinking clear fluids could also reduce the incidence of PONV, but at least in this group of patients that does not seem to be the case. Since there are no studies on this topic so far, further research is certainly necessary.

Reference:

A-18
Preoperative oral carbohydrate administration in ASA physical status III–IV cardiac surgery patients
J.P. Breuer, V.V. Dossow, C.V. Heymann, E. Mackh, C.D. Spies
Department of Anaesthesiology and Operative Intensive, Charité Campus Mitte, Charité – University Med, Berlin, Germany

Background and Goal of Study: Preoperative oral intake of carbohydrate-rich clear fluids in elective surgery patients (ASA I–II) is safe (1), improves preoperative well-being (2) and reduces postoperative insulin resistance (PIR) (3). This has not been tested in patients with higher ASA physical status.

Materials and Methods: Ethically approved 160 patients admitted for open heart surgery after giving written informed consent were randomly allocated to intake of a 12.5% carbohydrate drink (CHO, n = 56), flavoured water (Placebo, n = 60), or overnight fasting (Control, n = 44). CHO and Placebo were double-blinded and given to drink 800 ml during the evening before and 400 ml on the morning of surgery. Patients were monitored from induction of general anaesthesia (GA) until 24 hours postoperatively. Gastric fluid volume (GFV) was estimated according to intraoperative passive gastric reflux and subjective variables of preoperative discomfort were measured by 100 mm visual analogue scales. Blood glucose levels were equally controlled to ≤10.0 mmol/l by standardised insulin treatment. Exogenous insulin dosage was suggested as a surrogate marker for PIR. Statistics: Kruskal-Wallis-Mann-Whitney-U-Test, Brunner’s Analysis (ANOVA-type statistic).

Results: Thirst was significantly reduced in CHO [7 (0–75mm)] vs Control [30 (0–90mm), p < 0.01] and in tendency compared to Placebo [8 (0–76mm) p = 0.06]. The groups did not differ in GFV (CHO 0 (0–80ml) vs Placebo 0 (0–150ml) vs Control 0 (0–200ml), p = 0.38). Regurgitation or aspiration were not observed in any of the cases. Blood glucose levels and insulin dosages did not differ between groups (p = 0.49 and p = 0.65). Subgroup analysis of non insulin dependent diabetes mellitus (NIDDM) patients (CHO n = 10, Placebo n = 14, Control n = 8) did not show differences in blood glucose levels and insulin dosages (p = 0.28 and p = 0.47).

Conclusions: Oral intake of carbohydrate-rich fluids in ASA III–IV patients up to 2 hours before induction of GA does not seem to influence PIR; and particularly not in patients with NIDDM. Preoperative CHO can be recommended for patients up to ASA physical status IV.

References:
A-19
Supplemental oxygen reduce postoperative nausea but not vomiting after laparoscopic cholecystectomy
Department of Anaesthesia & Pain Clinic, General Hospital of Elefsina, Magoula – Elefsina, Greece

Background and Goal of Study: Postoperative nausea and vomiting (PONV) is one of the problems feared by surgical patients. Supplemental intraoperative oxygen is found to be effective or ineffective for PONV in some studies. The mechanism by which supplemental oxygen reduces PONV remains unknown but may be related to hyperoxia ameliorating sub- tle intestinal ischemia secondary to bowel manipulation and/or compres sion. We therefore tested the hypothesis that supplemental perioperative oxygen does not reduce the risk of PONV.

Materials and Methods: Sixty seven patients (ASA I–II, age 27–60), undergoing laparoscopic cholecystectomy were enrolled in a double randomized study. Anesthesia was induced with midazolam 20 mcg kg−1, fentanyl 2 mcg kg−1, propofol 2.5 mg kg−1 and cis-atracurium 0.15 mg kg−1. Patients were given sevoflurane–remifentanil anesthesia. The patients were randomly assigned in two groups, group 1 received 40% oxygen balance air (n = 33), group 2 received 80% oxygen balance air (n = 34). The incidence and the severity of nausea (none, moderate, severe) and the episodes of vomits were evaluated before living the PACU and then every 6th hour. Pain score was assessed with VAS score. A rescue antiemetic tropisetron 5 mg i.v. was available where nausea persisted for more than 30 min or 2 episodes of vomits.

Factors known to influence nausea and vomiting were comparable in two groups. We separately evaluate nausea and vomiting scores for 0 through 6 and 6 through 24 h. The results were compared with Pearson chi square.

Results: There were difference in the incidence of nausea the first 6 hours (P = 0.024), in total nausea (P = 0.038). There were no statistical difference in the results for the 6th to 24th hour for nausea, for vomiting the first 6 hours and for the 6th to 24th and in total vomiting (P > 0.05).

Conclusion: Supplemental intraoperative oxygen was effective in preventing nausea but not in preventing vomiting after laparoscopic cholecystectomy.

Reference:

A-20
The effects of pre-induction warming on preoperative anxiety in surgery patients
O. Kimberger, C. Sonnleitner, U. Illievich, R. Lenhardt
Department of Anesthesiology and General Intensive Care, Medical University of Vienna, Wien, Austria

Background and Goal of Study: Active warming of patients is not only able to improve thermal comfort, but has also been shown to reduce anxiety in a prehospital setting (1). We compared the efficacy of active warming with forced air in the preoperative holding area with passive insulation and/or midazolam.

Materials and Methods: 80 patients were randomized in 4 groups in the preoperative holding area:
1. passive insulation and placebo;
2. passive insulation and midazolam (30 μg/kg);
3. active warming with forced air and placebo;
4. active warming with forced air and midazolam (30 μg/kg).

After an initial set of measurements the designated treatment was instituted, a second set of measurements was performed in the OR, right before induction of anesthesia (30 min later). Thermal comfort and anxiety levels were assessed with VAS 0–100 (0 intense cold/no anxiety; 100 intense heat; severe anxiety) and patients’ anxiety was additionally measured with the Spielberger State-Trait Anxiety Inventory (STAI).

Results and Discussions:

<table>
<thead>
<tr>
<th></th>
<th>VAS 0–100</th>
<th>VAS 30 min</th>
<th>STAI-state</th>
</tr>
</thead>
<tbody>
<tr>
<td>Passive/Placebo</td>
<td>29.0 ± 12.9</td>
<td>36.3 ± 22.4</td>
<td>46.0 ± 10.1</td>
</tr>
<tr>
<td>Passive/Midazolam</td>
<td>33.2 ± 17.4</td>
<td>28.8 ± 19.7</td>
<td>41.7 ± 5.1</td>
</tr>
<tr>
<td>Active/Placebo</td>
<td>28.0 ± 18.2</td>
<td>14.0 ± 12.3</td>
<td>39.1 ± 4.9</td>
</tr>
<tr>
<td>Active/Midazolam</td>
<td>31.3 ± 17.0</td>
<td>34.7 ± 21.2</td>
<td>42.4 ± 5.6</td>
</tr>
</tbody>
</table>

All results first/second measurement; mean ± SD.
*p < 0.05; ANOVA for repeated measurements.

Conclusions:
1. Prewarming with forced air provides better thermal comfort in the preoperative area.
2. It does not reduce preoperative anxiety adequately in comparison to midazolam.
3. A combination of prewarming and midazolam can be recommended.

Reference:

A-21
Prospective randomised controlled trial of combination antiemetic prophylaxis in patients undergoing breast surgery
N. Kumar, H. du Plessis, P. Gururaj, J. Olson
Department of Anaesthetics, Grampian University Hospitals, Aberdeen, United Kingdom

Background and Goal of Study: Post operative nausea and vomiting (PONV) are common adverse events following surgery and is very distressing to the patient. The concept of balanced antiemesis using combination of antiemetic drugs has gained popularity in recent years and has been successfully used in gynecological surgery (1). Our intention was to examine whether the same benefits extended to patients undergoing breast surgery.

Materials and Methods: Following ethics committee approval and written informed consent 90 patients undergoing elective breast surgery were included in the study. The patients were randomly allocated into 3 groups to receive either placebo or dexamethasone 4 mg + ondansetron 4 mg or ondansetron 4 mg + cyclizine 50 mg. The drugs were administered intravenously at induction of anesthesia in a double blind fashion. A standardized anaesthetic technique was used. Diclofenac suppository and Bupivacaine 0.5% infiltration was used to supplement analgesia. Prochloperazine 12.5 mg was used as the rescue antiemetic in the recovery room. Patients were asked if nausea or vomiting had occurred in three time periods (0–3, 3–12 or 12–24 hours postoperatively with only 2 possible answers (yes/no). Continuous data was analysed using Student’s t test and ANOVA and other data was analysed using Chi-squared test.

Results and Discussions:

<table>
<thead>
<tr>
<th></th>
<th>Placebo(P)</th>
<th>ord + dexa(OD)</th>
<th>ord + cycl(OC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nausea 15(50%)</td>
<td>3(10%)</td>
<td>p &lt; 0.05, OD vs OC &amp; P</td>
<td>10(33%)</td>
</tr>
<tr>
<td>Vomiting 12(40%)</td>
<td>1(3%)</td>
<td>p &lt; 0.05, OD vs OC &amp; P</td>
<td>6(20%)</td>
</tr>
</tbody>
</table>

Conclusion(s): The combination of dexamethasone and ondansetron significantly decreased the incidence of nausea and vomiting after breast surgery.

Reference:

A-22
Optimizing the prediction of perioperative mortality in vascular surgery using a customized probability model
M.D. Kertai, E. Boersma, J. Klein, M. van Sambeek, O. Schouten, H. van Uerk, D. Poldermans
Department of Cardiology, H556, Erasmus MC, Rotterdam, The Netherlands

Background and Goal of Study: This study aimed to revise and customize the Revised Cardiac Risk (Lee) index to estimate the probability of perioperative all-cause mortality in patients undergoing noncardiac vascular surgery.

Materials and Methods: We studied 2,310 patients (mean age, 67.8 ± 11.3 years; males 1,747) who underwent acute or elective major noncardiac vascular surgery between 1991–2000 at the Erasmus MC. In a total of 1,535 patients was assigned for model development, in which the association between predictor variables and mortality occurring within 30 days after surgery were identified to revise and customize the Lee-index, which was then evaluated in a validation cohort of 773 patients.

Results and Discussions: The perioperative mortality rates were similar in the development (n = 103, 6.7%) and validation populations (n = 50, 6.1%). The customized risk-prediction model for perioperative mortality identified and allocated scores to type of vascular surgery (acute abdominal aortic aneurysm rupture, +43; thoraco-abdominal and abdominal aortic surgery, +26; infragenital bypass, +15; carotid endarterectomy, 0), ischemic heart disease (+13), congestive heart failure (+14), prior stroke (+10), hypertension (+7), renal dysfunction (+16) and chronic pulmonary disease (+7) associated
with increased risk, whereas beta-blocker (−15) and statin use (−10) with a lower risk of mortality.

whether anesthesia ended after 1600 h. RP algorithm CART (Classification & Regression Trees) was used to repetitively (recessively) divide (partition) the study population into subgroups in relation to the outcome; Fisher’s Exact Test was used for hypothesis testing, with $P < 0.05$ considered to indicate statistical significance.

Results and Discussion: CART correctly classified outcomes of 80% of subjects, identifying a set of predictors for unplanned admission similar to those identified with LR: Anesthetic method (general or spinal/epidural anesthesia vs. alternate methods) and duration were the strongest predictors, with smaller contributions from age, gender, and surgical severity. General or spinal/epidural anesthesia was associated with a 5-fold higher rate of admission compared to alternate methods ($P < 0.0001$), which was influenced by duration of anesthesia. Even among shorter cases, admission was more likely for older men having higher severity surgery.

Conclusions: RP provided a more intuitive and patient-centric view of risk of unplanned hospital admission after outpatient surgery. Its tree-like output identified sources of unplanned admission as the method exploited lack of homogeneity among the population and interactions among risk factors. Indeed, different subgroups had somewhat different risk factors for the same outcome. While LR presents relative importance of risk factors succinctly (e.g., odds ratios), such a presentation inherently averages influence of risk factors over the entire population and ignores heterogeneity of the population and possibilities of interactions among risk factors. RP and LR complement each other in providing a more comprehensive, informative perspective that is likely to be more helpful in quality improvement efforts.

A-25
Myasthenic crisis in patients after thymectomy – assessment of risk factors
J. Tyczka, J. Nadolski, C. Piekowski, W. Dyszkiewicz
Intensive Therapy Unit, Pulmonary Disease and Thoracic Surgery Center, Poznan, Poland
Background and Goal of Study: Thymectomy as a standard procedure in patients with myasthenia gravis (MG) may be responsible for postoperative exacerbation of symptoms of MG. Only few studies concerning this subject were published and their results are controversial. The aim of the study was to identify factors associated with the increased incidence of myasthenic crisis in the postoperative period.

Materials and Methods: We analyzed retrospectively the postoperative course in 67 patients (age 34.8 ± 13.7 y, 46 women and 21 men) after thymectomy operated on between 1995–2002. The following factors were evaluated: age, sex, grade of symptoms (MGFA Clinical Classification and Osserman classification), presence of bulbar symptoms, time from the onset of symptoms to thymectomy, anticholinesterase and steroid use, preoperative lung function (VC, FEV1, FEV1/VC), Leventhal scoring system, methods of anesthesia (TIVA or balanced anesthesia with inhalation agent, with or without TEA, use of myorelaxants) and surgery (sternotomy or video-assisted thoracic surgery), presence of thymoma and coexisting diseases. Statistical analysis was performed using chi-square test and $p < 0.05$ was regarded as significant.

Results and Discussions: Extubation after surgery was delayed in 23 patients (34.3%). Eight patients (11.9%) developed myasthenic crisis on 4 ± 1.4 postoperative day, 4 of them (50%) needed ventilatory support for 96 ± 8.5 h. Thymoma was found in 11 patients (16.4%). The statistical analysis showed that only MGFA clinical classification $> II A$ and VC $< 80\%$ were significant factors for development of myasthenic crisis in the postoperative period ($p < 0.05$). We found no correlation of preoperative status, anesthetic type or surgical approach with delayed extubation. Leventhal scoring system had no predictive value in this group of patients.

Conclusion: More advanced clinical stage of MG according to MGFA Clinical Classification and decreased vital capacity were identified as the risk factors for myasthenic crisis in postoperative period after thymectomy.

References:

A-26
Adrenal function during pre and postoperative phase in elective abdominal surgery
G. Schuepfer, F. Studer, S. Zweifel, C. Hunzern
Dept. of Anesthesiology, Kantonsspital Lucerne, Lucerne, Switzerland
Background and Goal of Study: Few epidemiological data exist on the adrenal function in patients undergoing elective abdominal surgery. Therefore

A-24
Recursive partitioning analysis provides a more patient-centric perspective on predicting adverse-event occurrence than logistic regression analysis
F. Orkin, L. Dohlan
Department of Anesthesiology, PennState University College of Medicine, Hershey, USA
Background and Goal of Study: To compare the usefulness of recursive partitioning (RP) to logistic regression (LR) analysis in studying the occurrence of unplanned hospital admission after outpatient surgery.

Materials and Methods: A case-control study had been conducted at a US university hospital and analyzed with LR. The data set was subjected to RP: 396 unplanned admissions (cases) and 396 patients not admitted (controls). The data included age, gender, ASA physical status, anesthetic method, duration of anesthesia, surgical severity (5-point clinical-invasiveness scale), and
patients with pathological adrenal response were identified by a preoperative ACTH stimulation test and followed till discharge.

**Materials and Methods:** After approval of the ethics committee and informed consent of the participants, adult patients scheduled for major abdominal surgery were enrolled in this study. Patients with a history of glucocorticoid therapy, endocrine diseases, acute pulmonary or any other medical comorbidities were excluded. For the low-dose ACTH test, an intravenous bolus injection of 1 mcg (1–24) corticotropin was given. Baseline and stimulated plasma cortisol were measured on the day before surgery (p1), immediately after surgery (p2), in the morning of the first postoperative day (p3) and the day of discharge (p4). A normal response to intravenous ACTH was defined as a stimulated plasma cortisol concentration >550 nmol/l (20 mcg/d).

**Results and Discussions:** 99 patients were included in this cohort study and all patients were followed according to the protocol. Pathological subgroup: At p1, 41 of 99 patients had a formal pathological ACTH test. 26 (63%) of this group (n = 41) had also a deficient response to ACTH immediately after surgery. On the first postoperative and the discharge day, in 20 patients (48.7%) the test remained pathological. The other patients of this subgroup had a normal response to ACTH under the surgical stress (p2–p4).

**Normal subgroup:** At p1 58 of 99 patients had a normal ACTH test. 36 (61%) of them (n = 58) had also a normal response to ACTH immediately after surgery. In 33 patients of this group the low dose ACTH test on the first postoperative day was normal. At discharge day, 40 patients were normal. The summarised results of the ACTH tests for both groups were as following: 58.6% of 99 patients at p1, 51.5% (n = 51) at p2, 54.5% (n = 54) at p3 and 60.6% (60) had a normal response to all the low-dose ACTH tests performed pre- and postoperatively.

**Conclusion(s):** In a high proportion of these cohort partial adrenal insufficiency can be diagnosed. In the majority of these patients the adrenal response to ACTH remains deficient in the postoperative time.

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**A-27**

**Intraoperative events: four years of a systematic collection**

E. Lambert, Y. Auroy, S. Ausset, C. Pelletier, T. Leclerc, B. Lenoir

**Department of Anesthesiology and Intensive Care, H.I.A. Percy, Clamart, France**

**Background and Goal of Study:** The systematic collection and analysis of incidents is highly recommended. The purpose of this study is to assess continuously collected events and to compare their associated factors.

**Materials and Methods:** From 01/2000 to 04/2004, every anesthesia is described with the patient features, the anesthetic technique and the occurrence of events (out of a list of 58), using a preformatted sheet then scanned and recorded in a data base. The herein analyzed events are bradycardia (brad), hypotension (hTA), hypoxemia SpO2 < 90% (hO2), bronchospasm (bronosp), unexpected difficult intubation (UDI), esophageal intubation (esint), regional anesthesia failure (RAf). A multivariate analysis was performed to analyze the associations between the factors and in quartiles (Q), Post- Anesthesia Care Unit length of stay (Q), surgery duration (Q), ASA physical status, emergency (versus elective surgery), number of spots on the response of 1 anesthesiologist.

**Results and Discussions:** All the anesthesia procedures have been analyzed (n = 11918). The odds ratio (OR) are:

<table>
<thead>
<tr>
<th>brad</th>
<th>hTA</th>
<th>hO2</th>
<th>bronosp</th>
<th>UDI</th>
<th>esint</th>
<th>RAf</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 2nd Q</td>
<td>0.83</td>
<td>1.68</td>
<td>1.07</td>
<td>0.83</td>
<td>1.92</td>
<td>2.07</td>
</tr>
<tr>
<td>Age 3rd Q</td>
<td>1.17</td>
<td>5.64</td>
<td>1.33</td>
<td>1.08</td>
<td>3.87</td>
<td>3.54</td>
</tr>
<tr>
<td>Age 4th Q</td>
<td>1.67</td>
<td>8.56</td>
<td>0.82</td>
<td>0.49</td>
<td>1.94</td>
<td>1.82</td>
</tr>
<tr>
<td>Paccu 2nd Q</td>
<td>2.31</td>
<td>2.54</td>
<td>1.09</td>
<td>1.85</td>
<td>0.97</td>
<td>1.89</td>
</tr>
<tr>
<td>Paccu 3rd Q</td>
<td>2.37</td>
<td>2.75</td>
<td>2.48</td>
<td>2.06</td>
<td>1.02</td>
<td>1.39</td>
</tr>
<tr>
<td>Paccu 4th Q</td>
<td>2.46</td>
<td>3.69</td>
<td>3.33</td>
<td>2.21</td>
<td>1.72</td>
<td>1.84</td>
</tr>
<tr>
<td>Surg 2nd Q</td>
<td>1.52</td>
<td>2.14</td>
<td>0.96</td>
<td>0.85</td>
<td>1.99</td>
<td>1.99</td>
</tr>
<tr>
<td>Surg 3rd Q</td>
<td>1.77</td>
<td>3.30</td>
<td>0.61</td>
<td>0.83</td>
<td>2.37</td>
<td>1.85</td>
</tr>
<tr>
<td>Surg 4th Q</td>
<td>2.40</td>
<td>5.04</td>
<td>0.91</td>
<td>0.69</td>
<td>3.38</td>
<td>1.53</td>
</tr>
<tr>
<td>ASA 2</td>
<td>0.77</td>
<td>1.26</td>
<td>2.07</td>
<td>1.50</td>
<td>1.18</td>
<td>0.87</td>
</tr>
<tr>
<td>ASA 3</td>
<td>0.67</td>
<td>1.37</td>
<td>4.90</td>
<td>1.25</td>
<td>1.28</td>
<td>0.96</td>
</tr>
<tr>
<td>ASA 4</td>
<td>0.11</td>
<td>1.55</td>
<td>5.49</td>
<td>1.00</td>
<td>1.20</td>
<td>1.20</td>
</tr>
</tbody>
</table>

Emergenc. | 0.47 | 0.79 | 1.15 | 1.45 | 1.33 | 1.39 | 2.03 |
An. > 1 spot | 1.06 | 1.11 | 1.50 | 1.35 | 1.17 | 1.17 | 1.15 |

Reference group (OR = 1) is not displayed. Age is strongly associated with hTA. OR are very dissimilar, some differences (hTA, brad vs the others) can be explained by the event collection method. May be organizational events could be better quality indicators in anesthesia practice.

**Conclusion:** Events should be studied separately (to adjust the size of the population exposed to the risk) and more clearly defined to become really relevant indicators.

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**A-28**

**Risk management valuing anaesthesiologist's experience**

S. Parente, R. Loureiro

**Department of Anaesthesiology, S. Francisco Xavier Hospital and Council for Quazi, Oeiras, Portugal**

**Background and Goal of Study:** Anaesthesiologists have an accumulated body of experience that can be used in risk management. How can one gather and systematise that lived experience in a way that can be useful in risk management.

**Materials and Methods:** Gathering and ranking of risk factors by means of a relation matrix filled in by senior anaesthesiologists (n > 43).

**Results and Discussions:** The information that emerged from the accumulated live experience of the senior anaesthesiologists points to a set of 3 groups of risk factors: poor leadership; poor communication; lacking of clear tested procedures (1”group”)

| production pressure | long hours (2”group”)
| poor facilities; poor or missing equipment; shortage of trained professionals (3”group”)

**Conclusion(s):** Relation matrix can be a useful method for acquiring and systematizing lived experience data into information relevant to risk management in anaesthesiology, providing a retrospective blame-free tool since it can be used anonymously.

**References:**
A-30

A survey of anaesthesia in Catalonia in 2003 (ANESCAT)


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Goal of Study: We conducted an extensive survey of anaesthetic activity in Catalonia in 2003 in order to know its impact on the general population, to quantify the workload and to describe common practices.

Methods: We designed a prospective, cross-sectional questionnaire survey asking anaesthesiologists to report every anaesthetic procedure performed on 14 randomised days in 2003. All public and private hospitals (131) practising anaesthesia around Catalonia (6,704,146 inhabitants) participated in the survey. This was a representative population sample and included data on characteristics of patients, anaesthetic techniques and type of procedure for which anaesthesia was required. We extrapolated anaesthetic activity according to demographics and calculated distribution of anaesthetic techniques and type of procedure. Data are expressed as medians (10-90%) or 95% confidence intervals.

Results: A total of 23,136 questionnaires were collected. This extrapolates to 603,189 anaesthetic procedures performed in Catalonia in 2003. Based on the current population, the annual rate of anaesthesia was 9% (95% CI: 8.6 to 9.4%). This rate ranged from 1.8% in girls aged 10–14 yr to 22% in men aged 75–79 yr. Fifty-eight percent of anaesthetic procedures were performed in women. The median patient age was 52 (21–78) yr. The percentage of cases assigned to ASA 3 was 28.6%, emergency 20.3% and outpatient 34.4%. Median duration of anaesthesia was 60 (26–75) min. Regional anaesthesia was the technique used most often (40%). Anaesthesia for orthopedics was the most frequent procedure (18.7%) and anaesthesia was used for non-surgical procedures in 10.4% of the cases.

Conclusions: Our results show an annual rate of anaesthesia similar to figures found in other national surveys (1.2). However, substantial qualitative differences were found in relation to practices such as kind of anaesthetic techniques and procedures for which anaesthesia was used. We think that national and multinational surveys would be useful in order to foresee changes in the evolution of the anaesthetic practices and workload in Europe.

References:

A-31

Physical status and major adverse events in 36,313 anaesthetics at tertiary hospital

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Background: The anaesthesic events adverse in a tertiary hospital in the Middle East have not been previously reported.

Aim of the Study: A prospective study of the major adverse anaesthetic events and its relation to patient physical status.

Methods: Data from 36,313 non-cardiac anaesthetics were collected over 5 years (1994–1999) American Society of Anesthesiologist’s Classification (ASA) was used for preoperative physical status assessment. Adverse events were recorded in the operating room by the anaesthetist, Post-Anesthesia Unit (P.A.C.U) and postoperative within 24 hours by an anaesthetist. Data were encoded using a customized database. Cardiac arrest, aspiration, neurological deficits, and death were analyzed using SAS software.

Results: ASA (3.45) were 29.9%, (2) was 39.6%, and (1) was 30.5%. Results were reported as rates/10,000 anaesthetics. Cardiac arrest was encountered in (5.51). Intraoperative was (3.03) and PACU was (2.48) and its relationship to ASA was highly significant (p-value < 0.001). Aspiration was encountered in 1.9 anaesthetics; intraoperatively (1.38) and PACU (0.55). Neurological deficits occurred in (2.2). The peri-operative mortality rate was (4.13) intraoperative was (0.083) and PACU was (1.65) and postoperative within 24 hours was (1.65), its relations to ASA were highly significant (p ≤ 0.0001). The percentage of aspiration and neurological events are related to the ASA classification but not statistically significant, because of the insufficient number of events. No major complication was recorded in case of respiratory sections.

Conclusion: The incidence of adverse events correlates with ASA physical status classifications. Preoperative identification and treatment of patient risk factors could improve anaesthetic outcome.

A-32

The anaesthetist in Croatia: patient’s view

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Background and Goal of Study: Anaesthesiologists as a discipline is taking great steps forward. In the last few decades, giving the anaesthesiologists the opportunity to move out of the shadow. Is a patient’s perception of an anaesthesiologist accordingly changing?

Materials and Methods: On a sample of 111 patients operated in our General hospital we tried to establish their perception of our duties and ourselves and to compare our results with similar foreign investigations, since such investigation has not been conducted in Croatia so far. The data were collected using a questionnaire distributed at the end of preoperative visit. We also examined the impact of an information booklet, provided only to the patients who preoperatively visited our preanesthetic clinic (54), as well as the impact of the previous operation to their knowledge (66). The results were compared using Chi-square test.

Results: Only 60.4% of our patients knew anaesthesiologists are doctors, comparing to 100% for surgeons and 80.2% for internists, which is comparable to study from Netherlands (1). Patients who were previously operated (69.7% vs 46.7%), as well as those who got the information booklet (74.1% vs 47.4%) were significantly better informed about this basic fact (p < 0.05). Except painless delivery (patients who got the information booklet were significantly better informed, p < 0.05), we could not establish any differences in the knowledge between the investigated groups. The results of our study are corresponding with the results of the recent study from Finland (2), especially concerning the duties outside the operating room.

Conclusions: The knowledge of our patients is poor, confirming the fact that anaesthesiologist still works in shadow. We can also confirm already established facts that previously operated patient does not mean well informed patient and the poor impact of the information booklet to the knowledge of our patients as well. Better knowledge about painless delivery is a bit surprising, since our study was not conducted in the obstetric department and we had more male examinons (60.4%).

References:
1. van Wijk MG, Smallhout B. Anaesthesia 1990;45:679-682.

A-33

Anaesthetic records – are we up to scratch?

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Background and Goal of Study: This project was undertaken to ascertain the quality of documentation associated with anaesthesia in Scotland. In 1996, recommendations as to the content of the anaesthetic record chart were published by the Royal College of Anaesthetists (RCoA). A 1997 study in North West England concluded that no anaesthetic chart compiled fully with these guidelines and suggested a review of the design of their charts.

Materials and Methods: We have performed a similar exercise and examined charts from 27 of the 29 NHS departments administering anaesthesia in Scotland. We also audited 202 ‘completed’ charts in two district general hospitals against the RCOA guidelines. This was in order to assess documented information, irrespective of printed data fields.

Results and Discussions: No Scottish anaesthetic chart was fully compliant with current guidelines, with the mean of recommended fields present being 50% (23–80%). In the two hospitals studied the anaesthetist present was only recorded on 68% and 85% of occasions respectively and the timing of drugs and fluid administration in 69% and 97% of cases. The fields for ‘name of patient’ and ‘operation performed’ were not present on 100% of forms! These omissions of information could cause problems for future anaesthetics or make legal cases less defensible and accountable.

Conclusions: There has been little improvement in standards of documentation and certain fields are consistently omitted. The anaesthetic chart is not a legal requirement but it could be construed that a lack of documentation reflects inattention of the anaesthetist for the patient.1 We have designed an anaesthetic chart that meets the RCOA criteria and could potentially be implemented throughout Scotland. It is available online at http://www.show.scot.nhs.uk/anaesthesia.asp.

References:
A-34
Clinical sings of neuromuscular blockade recovery as guideline for safety reversal assessment
R. Jankovic, S. Konstantinovic
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Background and Goal of Study: Different clinical sings have variable values in predicting neuromuscular blockade (NMB) recovery [1,2]. The goal of this study was to examine clinical sings of NMB recovery which could be used as a guideline for safety reversal assessment in the absence of adequate objective NMB monitoring.

Materials and Methods: We investigated 45 ASA I or II patients, during propofol-fentanyl anesthesia and pancuronium induced NMB. The patients were randomly allocated into 3 groups of 15, based on reappearance of the second (Group I), third (Group II), or fourth (Group III) TOF response in each anesthesia. NMB was evaluated by electromyography at the adductor pollicis muscle using a Datex Relaxograph® (T1, TOFr, number of TOF responses).

Before neuostigmine was administered, we evaluated the quality (poor, medium, good) of clinical sings that suggest NMB recovery such as: eye opening, tongue protrusion, ability to sustain arm lift >15 sec and head lift >5 sec. For analysis, we used the Kruskal Wallis test and Mann Whitney U test. Statistical significance was considered at p < 0.05.

Results and Discussions: Data are shown in Table. The results show that the hands of anaesthetists are significantly less sterile than the controls. Hand hygiene is important in preventing infection and it is our responsibility to take every reasonable precaution to reduce the risk of harmful sequelae.

Conclusion: This audit highlights our current poor practice. We must aim to improve upon our present hand washing technique. I suggest the best way we can do this is to follow the guidelines set by our own association.


A-35
How clean are we? – an audit studying hand washing for aseptic procedures amongst anaesthetists
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Background and Goal of Study: Anaesthetists perform procedures aseptically e.g. central line insertion, epidural and spinal anesthesia. Infection complications are rare but we should always strive to reduce the risk of adverse consequences. The purpose of this audit is to examine our handwashing technique. A literature search has revealed no similar studies.

Materials and Methods: 20 anaesthetists and 20 scrub nurses (controls) were studied. Once the subject had scrubbed they were asked to imprint their dominant hand onto a horse blood agar plate. These were incubated for 24 hours. The numbers of colony forming units (CFU) were then counted and the two cohorts compared.

Results and Discussions: Data are shown in Table.

<table>
<thead>
<tr>
<th>Clinical sign</th>
<th>Poor</th>
<th>Medium</th>
<th>Good</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye opening</td>
<td>Group I</td>
<td>4/15*</td>
<td>1/15</td>
</tr>
<tr>
<td></td>
<td>Group II</td>
<td>0/15</td>
<td>3/15</td>
</tr>
<tr>
<td></td>
<td>Group III</td>
<td>0/15</td>
<td>0/15</td>
</tr>
<tr>
<td>Tongue protrusion</td>
<td>Group I</td>
<td>9/15*</td>
<td>0/15</td>
</tr>
<tr>
<td></td>
<td>Group II</td>
<td>0/15</td>
<td>10/15</td>
</tr>
<tr>
<td></td>
<td>Group III</td>
<td>0/15</td>
<td>1/15</td>
</tr>
<tr>
<td>Arm lift &gt;15 sec</td>
<td>Group I</td>
<td>15/15</td>
<td>0/15</td>
</tr>
<tr>
<td></td>
<td>Group II</td>
<td>9/15</td>
<td>0/15</td>
</tr>
<tr>
<td></td>
<td>Group III</td>
<td>1/15</td>
<td>13/15</td>
</tr>
<tr>
<td>Head lift &gt;5 sec</td>
<td>Group I</td>
<td>15/15</td>
<td>0/15</td>
</tr>
<tr>
<td></td>
<td>Group II</td>
<td>15/15</td>
<td>0/15</td>
</tr>
<tr>
<td></td>
<td>Group III</td>
<td>0/15</td>
<td>7/15</td>
</tr>
</tbody>
</table>

*p < 0.05 I vs. II; **p < 0.05 I vs. III; †p < 0.05 II vs. III.

Conclusion(s): Eye opening and tongue protrusion might be used as a guideline for safety reversal assessment.


A-36
Are patients in Croatia as satisfied with anaesthesia service as elsewhere?
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Background and Goal of Study: Published papers on patient satisfaction with anaesthesia service reported high levels of patient satisfaction [1]. However, all of these studies came from high developed countries. Croatia belongs to the group of developing countries so we wanted to find out the level of patient satisfaction with anaesthesia service in Croatian hospital settings and compare it with the published results [2,3]. We hypothesized that the level of country's economic development is a predictor of satisfaction with anaesthesia.

Materials and Methods: We studied 220 consecutive patients having elective surgery during a 2-month period. Perioperative variables were gathered and patient satisfaction was assessed using our own developed questionnaire completed by the patient within 24 h of surgery. For the collection of perioperative data, written informed consent was not required by the ethics committee. Patient written informed consent was obtained for the postoperative questionnaire.

Results and Discussions: Table shows our results compared to published papers.

<table>
<thead>
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<th>Tong et al. [3]</th>
</tr>
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<tr>
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<td>98.8%*</td>
<td>98.3%*</td>
</tr>
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</table>

Compared to the published papers, there is no significant difference in reported level of satisfaction (p < 0.05).

Conclusion(s): Patients in Croatian hospital settings are as satisfied with anaesthesia care as the patients in high developed countries. Country's economic status has no impact on patient satisfaction with anaesthesia.


A-37
Perioperative complications correlate with acid–base balance in elderly trauma patients
G. Vitale, F. Sala, F. Consonni, M. Teruzzi, M. Greco, E. Bertoli, M. Bonacina, A. Oliva, P. Miasano
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Background and Goal of Study: The Fenci–Stewart approach to acid–base disorders, simplified by Story et al., estimates the base excess (BE) effects of strong ion, albumin (A) and unmeasured anions (UA). It has been suggested that the UA component of BE is a clinical marker for mortality in an Intensive Care population. We studied 220 consecutive patients having elective surgery during a 2-month period. Perioperative variables were gathered and patient satisfaction was assessed using our own developed questionnaire completed by the patient within 24 h of surgery. For the collection of perioperative data, written informed consent was not required by the ethics committee. Patient written informed consent was obtained for the postoperative questionnaire.

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Conclusion(s): Patients in Croatian hospital settings are as satisfied with anaesthesia care as the patients in high developed countries. Country's economic status has no impact on patient satisfaction with anaesthesia.

(both p < 0.01) with similar positive PV (BE: 100%; UA: 85%) and better negative PV for UA (BE: 64%; UA: 75%).

Conclusion(s): In elderly trauma patients, at risk for undetected hypovolemia and hypoperfusion, a simplified analysis of acid–base balance identifies patients who will develop perioperative complications. The hypothesis that UA effect may guide fluid therapy, leading to improved outcome, requires further evaluation.

References:

A-38
Quality survey of pre-operative assessment: influence of a standard questionnaire
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Dept. of Anesthesia, Ziekenhuis Oost-Limburg, Genk, Belgium

Introduction: Pre-operative assessment, allowing exchange of essential medical information between patient and anesthesiologist, is the best guarantee for not only a safe anaesthesia procedure, but also for a high patient satisfaction. Since recently, we introduced an electronic standard questionnaire, available for all patients, as guidance to our pre-operative assessments.

Materials and Methods: We prospectively surveyed all pre-operative data of all patients scheduled for week 22-2004. A resident, not involved in daily anaesthesia care, collected all data from the questionnaire, from the pre-operative assessment and from the medical record of the patient. An important issue was to analyse the role of the standard “yes-no” questionnaire in the whole pre-operative assessment process.

Results: A total of 425 patients were scheduled for an elective surgical procedure in week 22. 134 pts were admitted to hospital the day before surgery. For these pts, the use of a standard questionnaire did add very little relevant information, but was indeed largely dependent on the information given by the anesthesiologist.

Conclusions: A first survey of the quality of our pre-operative assessment supported the use of electronic standard questionnaires, especially for pts admitted on the day of surgery. Patient satisfaction with anesthesia seems indeed largely dependent on the information given by the anesthesiologist before surgery.

A-40
Patient preferences for desired post-anaesthesia outcomes – a comparison with medical provider perspective
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Background and Goal of Study: Intra-operative and post-operative adverse outcomes have been identified as the major causes of dissatisfaction with anaesthesia. The aim of this study was to identify patient preferences for post-operative anaesthesia outcomes in our population.

Materials and Methods: 100 pre-operative adult patients were given standardized preoperative information about anaesthesia. Each patient was asked to prioritize 11 possible anaesthesia outcomes using a relative value scale (willingness to pay was set to a total of 100 Euro). Each outcome was described in simple language. Peri-operative management was at the discretion of the anæsthesia provider. 26 medical and paramedical staff members also completed the survey.

Results and Discussions: 100 patients (mean age 44.77 ± 18.01) responded. 87 were undergoing elective and 13 emergency surgery. Patient rankings from (highest to lowest avoidance priority) were: vomiting, pain, breathing tube sensation, nausea, disorientation, bladder fullness, sore throat, shivering, thirst, itch, drowsiness. Broad variation was seen. Staff rankings for perceived patient preferences were: pain, vomiting, nausea, breathing tube, bladder fullness, disorientation, shivering, thirst, drowsiness, sore throat and itch. Willingness to pay was similar except for nausea (Staff vs. Patient, €16.7 ± 12.4 vs. €8.7 ± 18.8, p = 0.008).

Conclusion(s): There is broad correlation between medical staff and patient perceptions of desired outcomes. Individualized approaches to patient care are mandated by the wide variation in patient preferences.

References:

A-41
Measuring patient dissatisfaction with anaesthesia care
J.H. Schiff, S. Fornascher, M. Schiff, E. Martin, J. Motsch
Clinic of Anesthesiology, University of Heidelberg, Heidelberg, Germany

Background and Goal of Study: Current measures of patient satisfaction in anaesthesia care show an incorrect high satisfaction. In our study we tried to develop and validate a questionnaire that ought to detect patient dissatisfaction correctly.

Methods: Following the protocol of the psychometric design 192 items concerning the process of care could be identified. These were reduced to 72 anesthesia relevant items by excluding redundant and not anesthesia related items using sumscorces of questionnaires and interviews. After a pilot questionnaire consisting of 57 questions, reduction of items was made using a missing value analysis and probing questions. The final questionnaire was refined after a re-presentative test using statistical methods like Split-Half-, Chi²-, T-Test/Transformation, Cronbach’s-, Pearson-, Spearmans-Correlation etc. The final instrument consists of 39 questions, 32 concerning anesthesia related care in 5 dimensions. The questions are answered using a 4 scale likert response format and are presented in chronological order of anaesthesia care.

Results and Discussion: Until today, the final questionnaire was given to more than 350 patients 36 hours after discharge of the recovery room or ICU respectively. 84% of patients returned the questionnaire of which 77% were completed. Patients female: male ratio was 51:49, mean age was 52 (15–92). The mean time for answering the questionnaire was 12 (8–23) minutes.

Assessment of internal testreliability using cronbach’s 0.82 for the questionnaire, the dimension information gain was the only below 0.7 Cronbach’s (0.67). Younger Patients (<50 years) were significant more dissatisfied (p < 0.0005). Unsatisfied patients complained mostly about somatic disturbances (pain, thirst) and anxiety. Significant confounder were fear and the delay of the procedure in the dimension of anxiety (p < 0.005).

The more satisfied group of patients reached a total sumscore of 77% while the more dissatisfied group only 49%.

Conclusion: Compared to the previously used instruments with our psychometric designed questionnaire were found a lower satisfaction which more likely represent the “true patient satisfaction”, leaving room for improvement of perianesthesia care even in the group satisfied patients.

References:
12 Ambulatory anaesthesia

complete response (CR; no PONV, no rescue antiemetic) 0–2h or 0–24h postoperatively. Sample size calculation was performed before starting the trials by using a statistical power analysis (N = 40). Data were analyzed using Fisher’s exact test, Chi square test with Yates’ correction, Mantel–Haenszel test and Wilcoxon’s ranked sum test as appropriate.

Results: Data [mean (SD) or number (%)] are shown in the Table:

<table>
<thead>
<tr>
<th>Ond N = 43</th>
<th>Prop N = 42</th>
<th>Mod N = 44</th>
<th>Sa N = 42</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (yr)</td>
<td>52(11)</td>
<td>50(12)</td>
<td>49(14)</td>
</tr>
<tr>
<td>Weight (kg)</td>
<td>52(7)</td>
<td>53(6)</td>
<td>54(7)</td>
</tr>
<tr>
<td>0–2h Nausea</td>
<td>17(40)*</td>
<td>15(36)*</td>
<td>17(41)</td>
</tr>
<tr>
<td>Vomiting</td>
<td>1(2)**</td>
<td>2(5)**</td>
<td>1(2)**</td>
</tr>
<tr>
<td>CR</td>
<td>25(58*)</td>
<td>25(60*)</td>
<td>36(82)</td>
</tr>
</tbody>
</table>

*P < 0.05 vs Midazolam; **P < 0.05 vs Saline.

Conclusion(s): After using sevoflurane for induction and maintenance of anaesthesia with LMA:
1 midazolam group has a lower incidence of nausea and a higher complete response rate than other groups (0–2h);
2 the anti-vomiting effects (0–2h) and the incidence of PONV (0–24h) were no difference among groups.

References:

A-43 Can we define patients, which are at risk for post-operative pain after day case surgery?
H.-F. Granme, J.M. de Rijke, M. van Kleef, M.A.E. Marcus
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Background and Goal of Study: Despite an ongoing increase of ambulatory surgery, we know little which patients are at risks to have more pain after day case surgery. Postoperative pain not only causes discomfort and suffering, but also prevents the patient from resuming his daily activities. Severe postoperative pain may even have a negative impact on perioperative morbidity. These are important reasons for measuring post-operative pain. But most of the published papers on pain after ambulatory surgery lack a reasonable time for follow-up or did only measure a sub-group of this patient population. For future quality improvement, predictive factors, and course of post-operative pain is of the utmost importance. The purpose of our study was to assess the prevalence and intensity of postoperative pain during the first four days after the operation.

Materials and Methods: During a four-month period we enrolled 648 patients having ambulatory surgery at the day case unit of the university hospital of Maastricht, the Netherlands. A wide variety of operations were performed (general surgery, orthopedics, ophthalmology, gynecology, plastic surgery, ear-nose-throat, urology). Exclusion criteria were: age below 18 years, acute surgery, limitations of self-expression, and severe visual dysfunction. Using a visual analogue score (VAS) we evaluated postoperative pain before and up to four days postoperatively. Evaluations were made by direct questioning in hospital and using a pain diary after discharge from hospital.

Results and Discussions: Logistic regression analysis revealed that patients who have pain with VAS >40 mm on the day of the operation were more likely to have pain with VAS >40 mm during the following days. The younger age group (18–45 years) was more prone to have a VAS >40 mm than older patients. Preoperative presence of pain and preoperative expectation of pain were other predictive values for postoperative pain in our population.

Conclusion(s): In conclusion, special attention should be given to operations which are more likely to cause postoperative pain.

A-44 Continuous popliteal sciatic nerve block for postoperative pain control at home
E. Galvin, J. Blazquez, H. Medina, M. Meijer, S. Verbrugge, J. Klein
Department of Anaesthesiology, Erasmus University Medical Center, Rotterdam, The Netherlands

Background and Goals: Research suggests that perineural local anaesthetic infusion is generally well tolerated by ambulatory patients (1). The aim of this case series was to evaluate the effectiveness of regional analgesia using a sciatic popliteal perineural catheter and portable infusion pump in ambulatory patients, undergoing foot surgery.

Material and Methods: Preoperatively 20 patients received a sciatic nerve block and perineural catheter in the popliteal fossa. After surgery, theplexus catheter was connected to a disposable elastomeric infusion pump containing 100 mls of ropivacaine 0.2% infusing at a rate of 2 mls per hour. Patients were contacted by telephone on days 0, 1 and 2. Scores were recorded for pain: VAS (0–10), satisfaction: (Yes/Neutral/No) and motor function normal: (Yes/No). Difficulty and pain during catheter removal was also recorded.

Results:

Day 0 | Day 1 | Day 2
---|--|--|
Pain (VAS) mean | 1.3 | 1.6 | 1.5
Satisfied (Y/Neutral/N) | 19/1/0 | 19/1/0 | 19/1/0
Motor normal (Y/N) | 17/3 | 19/1 | 20/0

No patients reported difficulties with catheter removal. 100% would recommend the technique.

Conclusions: Continuous perineural local anaesthetic infusion pumps provide effective analgesia with a high patient satisfaction score in patients after ambulatory foot surgery.


A-45 The effects of remifentanil and dexmedetomidine on recovery in ambulatory gynecologic laparoscopies
N. Salman, F. Coskun, M.A. Salman, A.E. Salman, U. Aydar
Department of Anesthesiology and Reanimation, Hacettepe University Faculty of Medicine, Ankara, Turkey

Background and Goal of Study: Facilitating recovery after ambulatory surgery is still contentious (1,2,3). We aimed to compare dexmedetomidine with remifentanil with regards to their effects on recovery and post-operative side effects in ambulatory gynecologic laparoscopic surgeries.

Materials and Methods: After obtaining ethical approval we recruited 20–40 aged, 60 ASA I–II patients and randomized them into two groups. After induction with 2 mg kg−1 propofol, 0.05 mcg kg−1 min−1 remifentanil infusion was started following 1 mcg kg−1 bolus, in Group R. In Group D, 0.4 mcg kg−1 h−1 dexmedetomidine infusion was started following 1 mcg kg−1 bolus, 1 MAC desflurane in 35% N2O:65% O2 was used for maintenance. Infusions were titrated to keep BIS ≈ 50. Postoperative pain, nausea and vomiting were evaluated using VAS. First analgesic requirement, severity of pain, satisfaction with anesthesia and recovery were asked on phone 24 hours after discharge. Data were analyzed using Kolmogorov–Smirnov, t-test, Mann–Whitney U test, analysis of variance and p-values of <0.05 were considered to be significant.

Results and Discussions: Among all groups demographic and hemodynamic data were similar. Exubition (6.1–7.3 min.), recovery (9.1–10.5 min.), and orientation times (16.1–21.2 min.) were lower in group R. Patients in Group R were in hospitalized for a shorter time (88–124 min.). Postoperative pain scores were similar, but nausea scores were higher in Group R. In Group D, antiemetic requirements were lower compared to Group R. The patients in Group R needed more analgesics at home.

Conclusion(s): Although faster recovery is obtained with remifentanil infusion, dexmedetomidine infusion may be an alternative since it provides similar haemodynamics and lower incidences of postoperative nausea and vomiting and a decrease in analgesic requirements.

References:
2 White PF. Anaesth Analg 2000; 90; 1234–5.

A-46 No differences between low dose of dexametason and ondansetron in the prevention of postoperative nausea and vomiting in patients who undergo ambulatory laparoscopic gynaecological surgery
Departments of Anaesthesiology and Reanimation, Hospitals Vall d’Hebron, Barcelona, Spain

Background and Aim of study: Postoperative nausea and vomiting is a frequent complication of laparoscopic surgery. Several randomised trials have demonstrated that a single i.v. dose of 5–8 mg of dexamethasone is as effective as 4 mg of ondansetron. The efficacy of lower doses of dexamethasone has not yet been explored. We present the preliminary results of a clinical trial in women undergoing ambulatory laparoscopic gynaecological surgery.
Materials and Methods: We designed a prospective, double blind and randomised study were 99 women ASA I–III undergoing ambulatory laparoscopic gynaecological surgery under general anaesthesia received during the induction: Group D (n = 54); 4 mg dexamethasone, Group O (n = 42); 4 mg ondansetron. Patients suffering of diabetes or morbid obesity were considered non eligible. Both groups were comparable for age, weight, smokers, surgery’s duration, other risk factors for post-operative nausea and VAS of postoperative pain. T-test was used to compare quantitative variables, Fisher’s Exact test for qualitative variables, variables found significant at a level of p < 0.2 were considered in the multivariate model (logistic regression). Variables with a p-value <0.05 were considered significant.

Results: We did not found significative differences in the global incidence of nausea, vomiting and the need of anti-emetic rescue in between the two groups: nausea D = 27%, O = 36%, p = 0.38; vomiting D = 11%, O = 14%, p = 0.75 and need of rescue D = 16%, O = 21%, p = 0.61. No differences were found when the incidence of nausea, vomiting and need of rescue was analysed within the following time intervals: <1 hour from surgery, between 1 and 6 hours and between 6 hours after surgery and discharge (data not shown).

Conclusion: In this randomised study, we have not found differences between 4 mg of ondansetron and 4 mg of dexamethasone in the incidence of nausea, vomiting or the needs of anti-emetic rescue. Therefore dexamethasone should be recommended as the most cost-effective alternative.

A-47 Multimodal prophylaxis of postoperative nausea and vomiting in day-case anaesthesia

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Background and Goals: Incidence of postoperative nausea and vomiting (PONV) is still in the range of 25–30%. Risk scores for predicting them and a multimodal prophylaxis have been proposed to reduce the overall incidence (1). We compare the effectiveness of combined therapy in presence of sevofluorane or propofol anaesthesia in ambulatory surgery.

Materials and Methods: 330 patients with low to moderate risk factors (RF) were randomly assigned to sevofluorane or total intravenous anaesthesia (TIVA). The antecutaneous regimen was zero RF – no prophylaxis, one RF – 1 antietmic, two RF – 2 antietmics, three RF – 3 antietmics. The drugs used were: ondansetron 4 mg, droperidol 0.625 mg and dexamethasone 8 mg. Statistical tests used was t-Student and χ². A p value <0.05 was considered significant.

Results and Discussions: There were no differences in RF between groups. There was a higher proportion of maxillofacial surgery on sevofluorane group (p < 0.005).

<table>
<thead>
<tr>
<th>Sevofluorane</th>
<th>TIVA</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td></td>
<td>30 ± 14</td>
</tr>
<tr>
<td>Female (%)</td>
<td>58</td>
<td>55</td>
</tr>
<tr>
<td>PACU (%)</td>
<td>11</td>
<td>2.4</td>
</tr>
<tr>
<td>PACU (%)</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Surgery (min)</td>
<td>64 ± 23</td>
<td>70 ± 40</td>
</tr>
<tr>
<td>Discharge (min)</td>
<td>189 ± 59</td>
<td>173 ± 108</td>
</tr>
</tbody>
</table>

Conclusion: The multimodal approach to PONV is associated with a higher proportion of patients with a complete response in TIVA with propofol than sevofluorane anaesthesia.


A-48 Improved postoperative analgesia with additional IFB in hernia repair

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Background and Goal of Study: Since 2004, inguinal hernia repair must be done as day case in Germany. Yet it is one of the most painful procedures in ambulatory general surgery (1).

Materials and Methods: We studied 40 patients undergoing open hernia repair (20 with inguinal field block (IFB) and 20 without (w/o); age 55 ± 18 yrs). All patients received general anesthesia with Propofol/Remifentanil infusion and a PCA–i.v.-system with Piritramid. The block was performed pre-incisional after induction with 40 ml Bupivacaine 0.25%. We recorded pain (VAS 1–10) in rest and activity, Piritramid consumption (PC), patients satisfaction (PS), side-effects and recovery (PONV, dizziness, tiredness) (1–2 to +2; worst-best), delayed discharge (DD), anaesthetic and surgical time.

Results: Data (mean) are shown in the Table.

<table>
<thead>
<tr>
<th>Pain (VAS 1–10)</th>
<th>Rest</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>W/o IFB</td>
<td>With IFB</td>
<td>W/o IFB</td>
</tr>
<tr>
<td>PACU</td>
<td>5.4</td>
<td>5.2</td>
</tr>
<tr>
<td>After 4h</td>
<td>3.3</td>
<td>1.9</td>
</tr>
<tr>
<td>Night</td>
<td>1.8</td>
<td>1.5</td>
</tr>
<tr>
<td>Next morning</td>
<td>1.8</td>
<td>2.1</td>
</tr>
<tr>
<td>After 14 days</td>
<td>0.3</td>
<td>0.2</td>
</tr>
<tr>
<td>PS (–2 to +2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PACU</td>
<td>10.8</td>
<td>2.7</td>
</tr>
<tr>
<td>First 4h</td>
<td>5.0</td>
<td>1.3</td>
</tr>
<tr>
<td>After 14 days</td>
<td>1.3</td>
<td>1.8</td>
</tr>
<tr>
<td>PONV until morning</td>
<td>1.9</td>
<td>1.8</td>
</tr>
<tr>
<td>Surg. time (min)</td>
<td>52</td>
<td>49</td>
</tr>
<tr>
<td>Anesthetic time (min)</td>
<td>74</td>
<td>75</td>
</tr>
<tr>
<td>DD (days)</td>
<td>5</td>
<td>1</td>
</tr>
</tbody>
</table>

Conclusion(s): The IFB combined with general anesthesia is effective against pain and comfortable for the patient in ambulatory surgery. There is no extra time consumption nor are there any extra side effects. Without IFB, there is a higher risk of delayed discharge.


A-49 The effects of the lidocaine or fentanyl pretreatment on inhalation induction with sevoflurane

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Background and Goal of Study: Sevoflurane has been widely used for inhalation induction and intubation in children and adults. There are some reports about hemodynamic instability and respiratory effects during inhalation induction. We evaluated the effects of fentanyl, lidocaine, or both on inhalation induction and intubation using sevoflurane without neuromuscular blocking agents.

Materials and Methods: Sixty healthy adult female patients, 20 to 60 years old, premedicated with midazolam 3 mg were randomly received i.v. saline (Group A), lidocaine 1 mg/kg (Group B), fentanyl 1 µg/kg (Group C) or both lidocaine 1 mg/kg and fentanyl 1 µg/kg (Group D). Anesthesia was induced with 8% sevoflurane inhalation and intubation was done without muscle relaxant. A blind observer recorded the change of blood pressure, heart rate, BIS score, and the time needed for induction and intubation.

Results and Discussions: The mean times for BIS score below 40 were 87 ± 34 seconds and there were no significant difference among group. The mean times for loss of self respiration and intubation in Group A were significantly longer than those of other groups. The heart rates during induction and intubation of Group A were significantly greater than those of other groups. There was no significant difference in blood pressure and side effects during intubation among groups.

Conclusion(s): Pretreatment with fentanyl or lidocaine make smoother and faster induction and intubation during vital capacity rapid inhalation induction with sevoflurane.


A-50 Monitored anesthesia for ERCP in prone position using a target-controlled propofol infusion BIS-titrated

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Background and Goal of Study: Propofol is a short-acting, intravenously administered agent with a rapid recovery profile and good amnesic effects.
A-51
Propofol auto coinduction can aid laryngeal mask insertion. A prospective, randomised controlled trial
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Dept of Anaesthesia, Changi General Hospital, Singapore

Background and Goal of Study: Currently, common coinduction agents with propofol to aid LMA insertion include midazolam, fentanyl and alfentanil. In this study, we use small doses of propofol as an auto coinduction agent with propofol during anaesthesia induction and LMA placement.

Materials and Methods: 44 ASA I & 2 patients scheduled for surgical or orthopaedic procedures under GA were recruited. The study group (PP) received 0.5 mg/kg propofol 2 minutes before induction and the control group (SP) received 3 ml saline. Propofol was infused at 50 mg/kg/h until loss of eyelash reflex. LMA was inserted when patient was relaxed. We compared the time taken for induction and LMA placement, total dose of propofol consumed, haemodynamics changes during induction and conditions for LMA placement.

Results and Discussions: There is a significant reduction in the dose of propofol required for LMA insertion (100 ± 32.6 mg vs. 166 ± 41.1 mg, p = 0.00) and in the time taken for completion of LMA insertion (98.3 ± 19.3 min vs. 139 ± 42.1 min, p = 0.00) in the PP group. There was a higher proportion of patients in whom the jaw opening (86.95% vs. 63.6%, p = 0.00) and the ease of LMA insertion (85.5% vs. 59.1%, p = 0.00) were described as good in the PP group. The LMA was inserted within the first attempt in 90% of the patients in the study group. However, the incidence of side-effects was similar. There were significant decreases in mean arterial pressure within each group. However the incidence of side-effects was significantly lower in the PP group. The LMA was inserted within the first attempt in 90% of the patients. The process of co induction is also simplified by using the same agent.

Conclusion(s): There is a significant reduction in the dose of propofol and fentanyl administered were 560 mg and 60 mcg, respectively. There were no severe complica- tion observed; mean time to discharge was 20 minutes. Time to discharge was not influenced by the difficulty of ERCP or by the total dose of propofol administered.

Reference:

A-53
Patient-controlled dexmedetomidine sedation for day-case ophthalmic surgery
Department of Anaesthesiology and Reanimation, Zonguldak Karaelmas University, Zonguldak, Turkey

Background and Goal: Dexmedetomidine is a specific α2 adrenoreceptor agonist with sedative, analgesic and anesthetic-sparing effects (1). This prospective, randomized study evaluated the effects of dexmedetomidine during patient controlled sedation (PCS) in ophthalmic surgery.

Materials and Methods: After obtaining ethic committee approval and patient permission, 40 patients (ASA I–II) were randomized to receive dexmedetom- dine PCS (Group D, n = 20) or no intraoperative sedation (Group C, n = 20) during ophthalmic surgery performed under peribulbar block. The PCS solu- tion contained dexmedetomidine 2 μg/ml. The PCS parameters consisted of a loading dose of 1 μg/kg, a PCS dose of 5 μg and a lockout interval of 10 minutes. The study groups were compared with respect to intraocular pres- sure, hemodynamic parameters, perception of pain during peribulbar block with numerical rating scores (NRS), anxiety and discomfort NRS, intraopera- tive Ramsay Sedation Scale (RSS), Aldrete Scores in postoperative first 30 minutes, incidence of intraoperative complications, patient and surgeon satisfac- tion. Chi-square and Mann–Whitney U tests were used for statistical analy- ses. P value of 0.05 was considered significant.

Results: Patients in the Group D were administered a mean dexmedetom- dine dose of 66.4 ± 3.7 μg with a mean duration of 48.7 ± 3.2 min. Mean arterial pressure, heart rate, intraocular pressure, and NRS value during peribulbar block were lower in the Group D (p < 0.05). Patient satisfaction and RSS scores, incidences of dry mouth, and bradycardia were higher in the Group D (p < 0.05). Other intraoperative complications, surgeon satis- faction, anxiety and discomfort NRS and Aldrete Scores of the study groups were similar. In the PCS group none of the patients needed additional PCS dose after loading dose except two patients.

Conclusions: These results suggest that PCS with dexmedetomidine may be a useful technique in day-case ophthalmic surgery.

Reference:
including propofol and opioids without muscle relaxants (1). This study evaluated the intubating condition in oropharyngalgeal (ORL) ambulatory surgery with and without muscle relaxant and the immediate and intermediate post operative recovery.

**Methods:** We examined in three groups (n = 20 for each) of ASA I-II patients the intubating conditions four minutes after induction of anesthesia with remifentanil 0.5 mcg/kg/min, propofol 2 mg/kg without muscle relaxant (A) or with rocuronium 0.5 mg/kg (B) or with cisatracurium 0.15 mg/kg (C).

The time course of neuromuscolar block was determined by TOF Guard® using train of four stimulation (TOF). Anaesthesia was maintained with remifentanil 0.25 mcg/kg/min and propofol 6–8 mg/kg/hr. Residual block was antagonized at T1 recovery of 25% with neostigmine 50 mcg/kg and atropine 15 mcg/kg.

We have evaluated the intubating conditions with and without muscle relaxant: the onset time as maximal suppression of T1; time to 25% T1 recovery (duration of action), TOF ratio >0.9 recovery, postoperative recovery in phase I (Aldrete’s score = 9) and II (PADDS ≥ 9) (2,3).

**Results:** Intubating conditions were good or excellent in group B and C, in group A they were good only in 50% of patients because of cough and movements after orotracheal tube positioning.

**Conclusions:** Rocuronium and cisatracurium do not influence the discharge times in ambulatory surgery. The post anesthetic discharge scoring system (PADDS) show that the use of non depolarizing muscle relaxant has charge times in ambulatory surgery. The post anesthetic discharge scoring system (PADDS) show that the use of non depolarizing muscle relaxant has charge times in ambulatory surgery.

**References:**

**A-55**

**The comparison of lornoxicam–propofol and fentanyl–propofol combinations on ESWL**

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**Background and Goal of Study:** Extracorporeal shockwave lithotripsy (ESWL) represents the initial treatment modality in approximately 90% of patients undergoing emergency or elective procedures for urinary tract calculi. Various sedative and analgesic medication has been used for ESWL. The aim of this study was to compare the analgesic effect and side effects of propofol in combination with fentanyl or lornoxicam in ESWL.

**Material and Methods:** After approval of the local ethics committee and written informed consent were obtained, 23 patients (ASA class I-II, aged 25–59 years) undergoing elective ESWL (using Siemens Lithostar ESWL lithotripter) were included in the study. After arriving in the anaesthetic room and insertion of an i.v. cannula, baseline assessments of heart rate (ECG), noninvasive arterial pressure and pulse oximetry (SpO2), were performed. In all patient, 0.5 mg/kg of propofol was administered intravenously before ESWL. The patients were randomly allocated to receive either a bolus of 1 µg/kg-1 fentanyl followed by a continuous infusion of propofol at a rate of 1 mg/kg h-1 (Group PF; n = 12) or a bolus of 8 mg lornoxicam followed by a continuous infusion of propofol at a rate of 1 mg/kg h-1 (Group PL; n = 11).

Pain intensity was evaluated on a 0–100-mm visual analog scale (VAS). A supplemental analgesia with intravenous fentanyl 25 µg or 8 mg lornoxicam was given when inadequate analgesia occurred (VAS >3). Pain intensity (using VAS), the level of sedation (using the four-point score), and side effects of propofol in combination with fentanyl or lornoxicam was evaluated.

**Results:** There was no statistical difference between two groups in the demographic data, duration of ESWL procedure and hemodynamic parameters during ESWL. In group PF, the sedation scores were significantly higher than group PL (p < 0.05). The requirement of additional analgesic was higher in group PF than in group PL (5 versus 1 patients, p < 0.05). The incidence of oxygen supplementation was lower in PL group (n = 1; 9% patients) compared with that of PF group (n = 8; 66.7%) (p < 0.05).

**Discussion and Conclusion:** In conclusion, propofol–lornoxicam combination was found to be a better alternative for ESWL patients since this combination caused less respiratory depression and decreased the analgesic necessity.

**Reference:**
A-58
Changes in transcutaneous PCO₂ on earlobe represent hypoperfusion characterized by systemic increase in lactate
R. Ochialì, S. Tanaka, Y. Makii, H. Takahashi, T. Terada, Y. Hamada
Department of Anesthesiology, Toho University, School of Medicine, Ohta-ku, Japan

**Background and Goal of Study:** It has been shown that the increase in lactate and the reduction of intramucosal pH during cardiac surgery are due to hemodynamic instability which induces splanchnic and peripheral hypoperfusion (1,2). This study evaluated the change in transcutaneous PCO₂ (tcPCO₂) on the earlobe to test whether tcPCO₂ reflects the peripheral hypoperfusion during cardiopulmonary bypass (CPB).

**Materials and Methods:** 20 adult patients undergoing cardiac surgery using CPB were enrolled. Plasma lactate concentration and PaCO₂ were measured before and after CPB, along with tcPCO₂ on an earlobe (TOSCA, Linde, Switzerland). Peripheral blood flow on the earlobe was also measured using laser Doppler method. Relationship between lactate and PCO₂ difference (dCO₂ = tcPCO₂ – PaCO₂) was evaluated by using Chi square and ROC analysis, where p value and AUC were calculated.

**Results and Discussions:** 138 measurements were evaluated in 20 patients.

**Conclusion:** Although possible detrimental changes in respiratory function, MOP doesn’t require higher increase in VM to maintain normocapnia compared to normal-weight patients (18.5% ± 2 vs 16% ± 1.5); furthermore this ventilatory setting allowed to avoid high airway plateau pressures (paw), even if the gradient between paCO₂ and ETCO₂ showed a moderate increase.

**Reference:**

A-59
Minute ventilation required to maintain the normocapnia in laparoscopic bariatric surgery
L. Sollazzi, C. Modesti, T. Sacco, R. Caserta, V. Perilli
Department of Anesthesiology and Intensive Care, Catholic University of Sacred Heart, Rome, Italy

**Background and Goal of Study:** Resorption of CO₂ during laparoscopic surgery may have detrimental cardiovascular effects, especially in morbidly obese patients (MOP). The aim of this study is to determine the increase in minute ventilation (MV) required to maintain the normocapnia in MOP undergoing laparoscopic bariatric surgery.

**Materials and Methods:** 15 ASA physical class 2 MOP (BMI > 40) were studied. Furthermore 10 normal weight patients (control group – c) undergoing laparoscopic cholecystectomy was enrolled. The anaesthetic regimen was standard. All the patients were ventilated with a tidal volume 8–10 ml/Kg (ideal body weight). Respiratory rate (RR) was adjusted to maintain an ETCO₂ near 35 mmHg. The measurements of arterial blood gas tensions were made going tracheal intubation (1), 15’ after the beginning of pneumoperitoneum (PNP) (2), and then every 30’ until desufflation. RR was increased after abdominal insufflation in order to maintain ETCO₂ and PaCO₂ at or near baseline values. Abdominal pressure was set at 12 mmHg. Statistical analysis was performed by ANOVA for repeated measures.

**Results and Discussions:** Main intra-operative data are presented in Table.

**Conclusion:** In nine spontaneously breathing patients on PCA and L min⁻¹ O₂ post laparotomy we found relevant hypercarbia but no hypoaxemia using transcutaneous estimations of CO₂ and SpO₂ with Linde TOSCA.

**References:**
A-61
Comparison of two systems for measurement of pulmonary capillary blood flow by partial CO2 rebreathing
M. Gama de Abreu, T. Winkler, T. Pahltzsch, D. Weissmann, T. Koch
Clinic of Anesthesiology, University Carl Gustav Carus, Dresden, Germany

Background and Goal of Study: The pulmonary capillary blood flow (PCBF) can be measured by short periods of impairment of the CO2 elimination rate (VCO2), which lead endtidal CO2 partial pressure (PETCO2) to increase [1]. We compared two systems for measurement of PCBF that use different degrees of partial CO2 rebreathing.

Materials and Methods: Sixteen adult sheep were anesthetized and mechanically ventilated with the Evita 2 mechanical ventilator (Drägerwerk, Lübeck, Germany). PCBF was estimated noninvasively as VCO2/S. PETCO2 (5 = CO2 dissociation curve) with the DAVID Monitor (MedServ, Leipzig, Germany) (PCBFDav), which has a rebreathing deadspace of 200 ml, and by the Evita 2, which was modified to permit rebreathing maneuvers with a deadspace of 1000 ml and calculate PCBF (PCBF Evita). Measurements were performed at normal and impaired conditions of hemodynamics (variation of cardiac output) and gas exchange (variation of alveolar deadspace and shunt).

Results and Discussions: In total 144 pairs of measurements were obtained. Bias and precision calculations showed a tendency for PCBFEvita to overestimate PCBFDav, (0.3 ± 0.7 ml/min, p < 0.001).

Conclusion(s): The modified Evita 2 tends to overestimate PCBF values as measured by the DAVID Monitor. This is most probably explained by a non-linear relationship between VCO2 and PETCO2 in the presence of alveolar deadspace, which leads PCBF values estimated by almost total CO2 rebreathing to be higher than by minimal CO2 rebreathing.

Reference:

Acknowledgements: We acknowledge Drägerwerk AG for financial support.

A-62
Gravity influences accuracy and precision of pulse oximetry during simulated +1 Gz, 0 Gz, and –1 Gz
J. Hinkelbein, M. Dambier, J. Schindlewien, H.V. Gonzuwerker
University Hospital Mannheim, Institute of Anesthesiology and Intensive Care, Mannheim, Germany

Background and Goal of Study: Pulse oximetry is a reliable technique to determine functional oxygen saturation (SO2) with high accuracy and precision in the arterial blood. Multiple factors can influence the measurement; especially low perfusion [1] or venous congestion may severely decrease reliability. Reliability of pulse oximetry is poorly investigated under the influence of changes in gravity and acceleration.

Materials and Methods: After informed consent, five volunteers were investigated on a tilting table. One pulse oximeter (FRED, Brucker Medical, sensor BCI) was attached at the left earlobe (I=SpO2) to evaluate gravity effects. Another pulse oximeter (DigitTM, BCI) at the middle finger of the right hand at heart level (SpO2) served as reference (no gravity effect). Bias for oxygen saturation (SpO2/SpO2) and heart rate were calculated in upright standing position (simulation of +1 Gz for 4 min, 20 values each), in lying position (0 Gz, 4 min, 20 values), and head down position (-1 Gz, 4 min, 20 values). Wilcoxon-test was used for statistical analysis, p < 0.05 was considered to be significant.

Results and Discussions: All investigated volunteers were male with an average age of 26 ± 5 years and a BMI of 22.5 ± 2.1 kg/m². Bias during simulated +1 Gz (0.9 ± 0.1%, range –0.2% to –1.3%) and simulated 0 Gz (1.0 ± 0.7%, range –0.2% to –2.0%) changed not significantly (P = 0.67). With simulated –1 Gz in head down position bias increased to +1.7 ± 1.0% (range +0.3% to +3.7%, P < 0.001). Bias for the heart rate decreased from +3.3 ± 6.2 min⁻¹ vs. –3.6 ± 5.6 min⁻¹ (+1 Gz, vs. 0 Gz) to –10.1 ± 3.7 min⁻¹ during –1 Gz (P < 0.001).

Conclusion(s): Reliability of pulse oximetry determines functional oxygen saturation and heart rate at the earlobe is significantly lower during simulated –1 Gz compared to the reference measurement at heart level or during +1 Gz and 0 Gz. The reason may be venous congestion under negative Gz-gravity, which should be investigated further.

Reference:

A-63
Accuracy of three different techniques to determine pCO2 in a pig model
J. Hinkelbein, M. Barth, A. Kalenka, H.V. Gonzuwerker, E. Muench
University Hospital Mannheim, Institute of Anesthesiology and Intensive Care Med, Mannheim, Germany

Background and Goal of Study: Arterial blood gas analysis (ABGA) remains the gold-standard to determine carbon dioxide partial pressure (pCO2). End-tidal techniques (pETCO2) are easy to establish, but may be inaccurate. A new transcutaneous monitor (ptcCO2) allows continuous measurement of CO2. Accuracy and precision are evaluated in an animal model.

Materials and Methods: After approval of the local ethics committee for animal research pCO2 (Datex Ohmeda, Helsinki/Finland), pETCO2 (ABL500, Radiometer/Denmark), and ptcCO2 (TCH4, Radiometer/Denmark) were determined simultaneously in six intubated and ventilated house pigs during normo-, hyper-, and hyperventilation. The bias for the measurement was calculated as B = pETCO2 - ptcCO2 and B = pTCO2 - pETCO2. T-test was used for statistical analysis, p < 0.05 was considered significant.

Results and Discussions: 61 data sets (pCO2, pETCO2, and ptcCO2) were acquired in six female house pigs (30 ± 5 kg). During normoventilation (respiratory rate 13 min⁻¹, tidal volume 10 ml kg⁻¹, pCO2 = 40.0 ± 4.0 mmHg, n = 27) bias for the end-tidal (Bet 1 = ±3.0 ± 2.3 [-0.2 to +10.0] mmHg) and transcutaneous measurement (Bet 2 = ±4.5 ± 6.0 [-16.1 to 31.0] mmHg) were comparable. During hyperventilation (respiratory rate 6 min⁻¹, tidal volume 6 ml kg⁻¹, pCO2 = 55.8 ± 5.7 mmHg, Bet 1 = ±1.7 ± 6.8 mmHg, Bet 2 = ±3.8 ± 4.9 mmHg, n = 17) and hyperventilation (respiratory rate 21 min⁻¹, tidal volume 12 ml kg⁻¹, pCO2 = 28.7 ± 4.3 mmHg, Bet 1 = ±2.6 ± 0.9 mmHg, Bet 2 = ±4.1 ± 4.8 mmHg, n = 17) no difference in bias could be found.

Conclusion(s): In this trial in an animal model a good correlation between the three different techniques to determine pCO2 was found during normoventilation as well as during hypo- and hyperventilation. Transcutaneous and end-tidal monitoring allow reliable and comparable readings of pCO2.

A-64
The resistance of current anaesthetic breathing systems
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Background: When a patient breathes through an anaesthetic breathing system an extra resistance is imposed on their respiratory muscles. This extra resistance may be overcome or may lead to hypoventilation and reduced gas exchange. A simple means of assessing breathing system resistance is to measure the pressure drop (PD) at a specified flow. The International Standard for breathing systems defines this flow and states that the PD at the patient connection port should not exceed 0.6 kPa (1). This study aims to determine the resistance of current anaesthetic breathing systems.

Methods: We tested 5 samples each of 10 1.6m breathing systems (4 Bain’s coaxial, 3 Mapleson A [Map A] and 3 parallel systems) using a fresh gas flow of 10 L min⁻¹ and a sine-wave pump, to simulate spontaneous breathing, set to 1 L tidal volume at 20 min⁻¹. Pressures and flows were measured using a Datex AS/3 monitor. All data were recorded onto a laptop using Lab VIEW software.

Results:

<table>
<thead>
<tr>
<th>Manufacturer</th>
<th>Mean (SD) max PD (kPa)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bain</td>
<td>0.87 (0.13) [0/5]</td>
</tr>
<tr>
<td>Map A</td>
<td>0.88 (0.18) [2/5]</td>
</tr>
<tr>
<td>Parallel</td>
<td>0.78 (0.03) [2/5]</td>
</tr>
<tr>
<td>Flexicare</td>
<td>1.43 (0.14) [2/5]</td>
</tr>
<tr>
<td>Intersurgical</td>
<td>1.43 (0.14) [2/5]</td>
</tr>
<tr>
<td>Mallinckrodt</td>
<td>0.77 (0.02) [0/5]</td>
</tr>
</tbody>
</table>

Monitoring: equipment and computers 17

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Conclusion(s): Similar breathing systems from different manufacturers showed very different pressure drops and therefore resistance. Only 10 of the 50 systems tested complied with the requirements of the standard.

Reference:
1 BS ISO 8835-2:1999.

Acknowledgements: Flexicare, Intersurgical, Armstrong and Mallinckrodt for the samples.

A-65

Real time dependency of subcutaneous tissue oxygenation on inspired oxygen concentrations

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Background and Goal of Study: Supplemental peri-operative oxygen administration increases subcutaneous tissue oxygenation. The exact correlation over time between tissue oxygenation and FiO2 is unknown. Consequently we evaluated subcutaneous tissue oxygen tension of the upper arm (PsqO2) and of the wound (PwO2) in relation to inspired oxygen concentrations (FiO2). All data were recorded online.

Materials and Methods: So far we have evaluated data in two patients (A, B). Intraoperatively PsqO2 was measured, whereas postoperatively PsqO2 and PwO2 in the subcutaneous tissue adjacent to the surgical wound were obtained. Additionally we recorded hemodynamic and respiratory data (e.g. CO2, FiO2). All data were recorded online.

Results: Our preliminary results show that there is a close relationship over time between PsqO2 and FiO2. Furthermore tissue oxygenation at the wound is well reflected by subcutaneous tissue oxygenation in the upper arm.

Intraoperative

Intraoperative

Postoperative

Postoperative

Intraoperative

Intraoperative

Postoperative

Postoperative

Conclusion: Intraoperatively PsqO2 was measured, whereas postoperatively PsqO2 and PwO2 in the subcutaneous tissue adjacent to the surgical wound were obtained. Additionally we recorded hemodynamic and respiratory data (e.g. CO2, FiO2). All data were recorded online.

Materials and Methods: So far we have evaluated data in two patients (A, B). Intraoperatively PsqO2 was measured, whereas postoperatively PsqO2 and PwO2 in the subcutaneous tissue adjacent to the surgical wound were obtained. Additionally we recorded hemodynamic and respiratory data (e.g. CO2, FiO2). All data were recorded online.

Results: Our preliminary results show that there is a close relationship over time between PsqO2 and FiO2. Furthermore tissue oxygenation at the wound is well reflected by subcutaneous tissue oxygenation in the upper arm.

A-66

Duration and extent of the decline SpO2 after low-dose injection of methylene blue

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Background and Goal of Study: With regard to previous studies (1) reporting of artificial low readings of functional oxygen saturation (SpO2) after injection of methylene blue (MB), this study was designed to indi-vidually evaluate duration and extent of the spurious de-crease in SpO2 of four pulse oximeters, each representing the newest technology.

Materials and Methods: After IRB approval and in-formed consent, SpO2 of 20 patients (58-92 yrs) under-going transurethral vesical surgery and receiving 50 mg MB intraoperatively to localize the urethral orifices was simultane-ously measured with four pulse oximeters (Philips IntelliVue M3001, Masimo Radical, Dolphin Medical 2100, Nellcor N-595) via four randomly placed sen-sors (digit II–V). Minimum SpO2 (t1) as well as be-ginninging (t2) and end (t3) of the decline of SpO2 were marked offline and Δt1 – t2 – t3, Δt1 – t3 – t2 and ΔSpO2 = SpO2(t1) – SpO2(t2) were calculated.

Results and Discussions: Data (mean ± SD) are shown in the table:

<table>
<thead>
<tr>
<th></th>
<th>Philips IntelliVue</th>
<th>Masimo Radical</th>
<th>Dolphin Medical</th>
<th>Nellcor N-595</th>
</tr>
</thead>
<tbody>
<tr>
<td>Δt1 (s)</td>
<td>23.6 ± 5.2</td>
<td>19.4 ± 7.0</td>
<td>20.5 ± 7.2</td>
<td>24.7 ± 6.3</td>
</tr>
<tr>
<td>Δt2 (s)</td>
<td>128.1 ± 43.2</td>
<td>100.4 ± 33.0</td>
<td>143.5 ± 45.0</td>
<td>112.6 ± 32.4</td>
</tr>
<tr>
<td>Δt3 (s)</td>
<td>37 ± 10</td>
<td>51 ± 14</td>
<td>46 ± 11</td>
<td>37 ± 7</td>
</tr>
</tbody>
</table>

There are only slight statistical differences of Δ t1 with all pulse oximeters. Dolphin Medical shows the largest recovery time and as well as Masimo Radical the deepest decline of SpO2, significantly differing from Nellcor N-595 and Philips IntelliVue.

Conclusion: Variably differing SpO2 readings with newest generation pulse oximeters after MB injection do not allow to conclude on pathophysiological alterations of oxygen delivery. Further investigations are needed to de-terminate whether or not the decline in SpO2 may correlate to a change in arterial oxygen saturation (SaO2).

Reference:

A-67

IV Injection of low-dose methylene blue causes a decrease in pO2

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Background and Goal of Study: Due to its peak absorption at 609 and 668 nm, methylene blue (MB) is known to cause transient, but artifactual low readings (1) of the functional oxygen saturation (SpO2). This study was designed in order to determine whether or not this spurious decrease in SpO2 is associated with a concurrent alteration of the arterial pO2 after MB injection.

Materials and Methods: After institutional approval and informed consent, SpO2 data of 16 patients (58-92 yrs) undergoing transurethral vesical procedures and receiving 50 mg of MB intraoperatively to visualize the urethral orifices, were assessed by means of four fourth generation pulse oximeters. An arterial line was placed into the contralateral radial artery and arterial blood gas samples were taken to determine the pO2 (Radiometer ABL700) prior to the IV injection of MB (t1: pO2(t1)), at minimum SpO2 (t2: pO2(t2)), and after SpO2 hav-ing returned to its baseline (t3: pO2(t3)). The differences between pO2(t1) and pO2(t2) (ΔpO2(t1-2)) and pO2(t2) and pO2(t3) (ΔpO2(t2-3)), respectively, were calcu-lated for each patient. Additionally, the interval between t1 and t2 (Δt1) and t2 and t3 (Δt2) was determined.

Results and Discussions: Data (mean ± SD) are shown in the table:

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>ΔpO2(t1-2) (mmHg)</td>
<td>48.4 ± 20.1</td>
<td>±8.6</td>
</tr>
<tr>
<td>ΔpO2(t2-3) (%)</td>
<td>33.3 ± 13.6</td>
<td>±7.6</td>
</tr>
<tr>
<td>Δt1 (s)</td>
<td>23 ± 6</td>
<td>±38</td>
</tr>
<tr>
<td>Δt2 (s)</td>
<td>123 ± 8</td>
<td>±0.001</td>
</tr>
</tbody>
</table>

p < 0.001.

Average pO2 appears significantly reduced by 15 mmHg approximately, although SpO2 has already returned to its initial level.

Conclusion: The IV injection of low-dose MB causes a significant drop in pO2, therefore further research is required to investigate the underlying pathophysiology.

Reference:
1 Anesthesiology 1989;71:791–794.
Cerebral oxymetry versus mixed venous oxymetry during hypothermic hemodilutional cardiopulmonary bypass

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Principle and Goal of study: During cardiopulmonary bypass (CPB), mixed venous oxygen saturation (SvO2) has been traditionally used as an indicator of whole body oxygen supply/demand. Recently, the INVOX monitor has been used for non-invasive and direct assessment of cerebral blood oxygen saturation (R02). This study was undertaken to compare R02 and SvO2 during hypothermic hemodilution CPB.

Materials and Methods: Fourteen patients undergoing elective cardiac surgery using hypothermic hemodilution CPB were included in the study. During CPB, R02 and SvO2 were continuously monitored with a cerebral oximeter (INVOX S100B) via a surface electrode placed on the patient’s forehead and with the mixed venous oximeter (Bently Oxy-Sat meter) integrated in the cardiopulmonary bypass machine (Sarns 5000) respectively. Mean ± SD of R02, SvO2, PCO2, Hct, and CO were determined during pre-bypass and during CPB at 31°C and 35°C. Statistical analysis were performed with the analysis of variance (ANOVA) and level of significance was considered at p < 0.05.

Results: Data (Mean ± SD) are shown in the table:

<table>
<thead>
<tr>
<th></th>
<th>Pre-bypass</th>
<th>Cooling 31°C</th>
<th>Rewarming 35°C</th>
</tr>
</thead>
<tbody>
<tr>
<td>R02 (%)</td>
<td>76.0 ± 9.6</td>
<td>58.9 ± 6.4*</td>
<td>67.1 ± 8.7*</td>
</tr>
<tr>
<td>SvO2 (%)</td>
<td>78.6 ± 3.3</td>
<td>68.9 ± 3.6*</td>
<td>74.1 ± 6.9*</td>
</tr>
<tr>
<td>PCO2 (mmHg)</td>
<td>43.5 ± 8.9</td>
<td>32.6 ± 3.1†</td>
<td>37.9 ± 3.1†</td>
</tr>
<tr>
<td>Hct (%)</td>
<td>38.2 ± 5.1</td>
<td>27.7 ± 4.1†</td>
<td>28.5 ± 3.8†</td>
</tr>
<tr>
<td>CO (l/min/m²)</td>
<td>4.6 ± 0.9</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Pump Flow (l/min/m²)</td>
<td>N/A</td>
<td>2.4</td>
<td>2.4</td>
</tr>
</tbody>
</table>

*p < 0.05 vs. Pre-bypass; †p < 0.05 vs. Cooling. Corrected

Conclusions: During hypothermic CPB, there was a significant increase of SvO2 associated with a paradoxical decrease of R02. The decrease in R02, despite the decreased cerebral oxygen consumption during hypothermic CPB, may be attributed to the possibility of decreased cerebral oxygen supply secondary to the α-stat strategy of CO2 management which decreased temperature-corrected PCO2 during hypothermia down to 26.8 ± 3.1 mmHg.

References:

Orbital ultrasound monitoring during cardiopulmonary bypass and neuropsychological function following cardiac surgery

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Background and Goal of Study: Cerebral dysfunction following cardiopulmonary bypass (CPB) remains a major source of morbidity and mortality in cardiac surgery, with early diagnosis required for the prevention of neurological complications. Orbital ultrasound (OUS) monitoring can provide useful information regarding intracranial blood flow during a CPB procedure (1). The objective of the present study was to evaluate the clinical significance of quantitative OUS findings during cardiac surgery in terms of their relevance to postoperative neurological events.

Materials and Methods: We studied 30 adult patients scheduled for coronary artery bypass grafting or valve replacement surgery. A mini-mental state examination (MMSE) was performed 2 days before, and 7 and 14 days after the operation. OUS observations were made before, 20, 40, and 60 minutes after the start, and after the end of CPB. Maximal flow velocity (Vmax) in the central retinal artery (CRA) and MMSE scores after the operation were compared using regression analysis. Further, Vmax and the occurrence of postoperative neurological events were compared using a chi-square test.

Results and Discussions: MMSE scores were significantly decreased 7 days after the operation and then returned to preoperative levels by 14 days. No significant correlations were seen between Vmax at any time point during CPB and postoperative MMSE scores. Delirium occurred in 5 cases (17%), whereas no major complication, such as stroke, occurred. Each of those patients showed significantly lower MMSE scores after the operation as compared to the other patients, and OUS monitoring detected CRA blood flow during CPB. We considered that the absence of significant correlations between Vmax and postoperative neurological events may be due in part to the absence of major neurological complications in the present cases.

Conclusion(s): The Vmax of CRA blood flow obtained by OUS monitoring could not predict postoperative neurological events. Additional studies for quantitative evaluation of OUS monitoring during CPB when used as an indicator of postoperative minor neurological dysfunction are needed.

References:

P02 as a marker for renal blood flow in laparoscopic versus open donor nephrectomy

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Background and Goal of Study: Laparoscopic donor nephrectomie (LDN) is performed more often because of reduced postoperative morbidity and shorter hospital stay. Animal studies have shown however a reduced renal blood flow (RBF) during pneumoperitoneum (1). To measure RBF, invasive techniques should be used, however earlier investigators suggested that urinary oxygen tension (P02) is related to renal medullar blood flow (RmBF) (2). This study is the first prospective randomised study where RBF is measured and comparing LDN and open donor nephrectomy (ODN) patients.

Materials and Methods: 32 patients in the LDN en 33 in the ODN group, were included. Anaesthesia was performed with a fixed protocol and continu-us FiO2 of 40%. High dosage of morfomimetica and liberate fluid regime of colloidis and crystalloidis starting before operation was used. P02 samples were obtained on 2 moments.

Results and Discussions: 9 patients from the ODN and 3 patients from the LDN group had to be excluded. Both operation techniques cause an equivalent and a significant (p < 0.05) increase in P02 after two hours of operation. No difference is found in P02 between LDN and ODN.

A-70

Single transpulmonary thermodilution during off-pump coronary artery bypass grafting

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Background and Goal of Study: An off-pump modification of coronary artery bypass grafting (OPCAB) is intended to avoid complications related to cardiopulmonary bypass, but can be accompanied by severe changes in hemodynamics requiring advanced monitoring (1). The transpulmonary single thermodilution (STD) is a novel method for cardiovascular monitoring allowing the simultaneous evaluation of myocardial preload and contractility as well as quantification of lung edema (2). However, the role of STD in off-pump cardiac surgery is still unsettled. Thus, our aim was to evaluate the use of STD in OPCAB.

Materials and Methods: We studied 11 patients who underwent elective OPCAB during total intravenous anesthesia (propofol and fentanyl). Before surgery, a 5F thermodilution catheter (Pulsiocath PV2014L20) was inserted into the femoral artery. Heart rate (HR), cardiac index (CI), cardiac function index (CFI), stroke volume index (SVI), stroke volume variations (SVV), global ejection fraction (GEF), left ventricular contractility index (dP/dmax), systemic vascular resistance index (SVRI), and other hemodynamic parameters were assessed by STD and continuous pulse contour analysis (PICCOplus, Pulsion Medical Systems, Germany). The measurements were performed after


induction of anesthesia, during and at the end of surgery, and at 2, 4, and 6 hrs postoperatively. The data were analyzed using the test of contrasts.

**Results and Discussions:** After induction of anesthesia, HR, CI, CFI, SVI, GEF, and dPmax declined in concert with an increase in SVRI (p < .05). During revascularization, dPmax and SVRI decreased transiently by 25% (p < .05) that necessitated administration of epinephrine in 8 of the patients. After the OPCAB, HR, CI, CFI, and SVV increased significantly in parallel with fluid resuscitation and intravenous infusion of nitroglycerin. These changes, as well as a decrease in SVRI by 20% (p < .05), were also observed postoperatively.

**Conclusion:** During OPCAB, STD is a valuable tool for monitoring of the volume status, myocardial performance, and vascular tone that might help in providing an adequate goal-directed hemodynamic management.

**References:**

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**A-73**

**Correlation of peripheral venous and central venous pressures after major surgery in the postanesthesia care unit**

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**Background and Goal of Study:** Correlation of central venous pressure (CVP) and peripheral venous pressure (PVP) in ASA II–III patients after major surgery.

**Materials and Methods:** A prospective repeated measures study was performed on 16 patients in our postoperative intensive care unit (ICU). All patients had peripheral venous lines and required CVP monitoring. CVP and PVP were measured pairwise every hour during the first 5 hours after surgery. If typical sinusoidal wave forms were not seen on PVP tracings, the patient was excluded from the study (n = 4). All patients were spontaneously breathing and reclining with the head at 30°. The CVP was placed at the superior vena cava. The peripheral venous catheter was standard peripheral over-the-needle catheter of different sizes (20 to 14 gauge), and were placed at the forearm or hand.

**Results and Discussions:** All patients were ASA II–III required a postsurgical ICU because of major surgery and patient comorbidity. This preliminary results showed a good correlation during the first 5 hours after surgery: r = 0.8, r2 = 0.9, r0.8 = 0.86, r0.88 respectively (p < 0.01). The mean values and SD of PVC and PVP during the first 5 hours were: 1st: 6.69 (3) and 9.5 (3.8), 2nd: 7.25 (3.2) and 9.88 (3.5), 3rd: 7.13 (3.8) and 9.13 (3.7), 4th: 6.44 (2.8) and 9.19 (3.3), 5th: 6.19 (2.8) and 8.56 (2.8) respectively. The bias (mean difference between CVP and PVP) during the first 5 hours was 2.5 (SD1:5) mmHg.

**Conclusion:** PVP measurement may be a noninvasive alternative for estimating PVC at the PACU, in spontaneously ventilating ASA II–III patients without significant cardiac dysfunction undergoing major surgery.

**Reference:**

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**A-74**

**Could central venous oxygen saturation be an attractive alternative to mixed venous oxygen saturation in cardiac surgery with cardiopulmonary bypass?**

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**Background and Goal of Study:** Central venous oxygen saturation (ScvO2) may be an interesting alternative to mixed venous oxygen saturation (SvO2) in patients without a need of a pulmonary artery catheter (1). The aim of this study was to evaluate the relation between ScvO2 and SvO2 in patients scheduled for cardiac surgery with cardiopulmonary bypass (CPB).

**Materials and methods:** 33 patients (10 patients with coronary artery bypass grafting (CABG), 7 patients with valve replacement and CABG, 16 patients with valve replacement) after written and informed consent were included in this prospective study. A TCI remifentanil – propofol – cisatracurium anesthesia was used. TIP placement of the catheters in the pulmonary artery (Swan-Ganz©, 7.5F, American Edwards Lab) and in the superior vena cava (7F triple lumen, Arrow©) was controlled by Transesophageal Echocardiography. Blood samples were drawn at induction (T1), 10 minutes after CPB (T2) and after arrival in the intensive care unit (T3). The blood samples were immediately analysed for oxygen saturation by Instrumentation Laboratory 682 CO-Oximeter. Statistical analysis was performed by linear regression, Pearson correlations and the method of Passing and Bablok (2).

**Results:** Mean values ± SD, correlations (R) and confidence limits of 95% for ScvO2 and SvO2 at T1, T2 and T3:

| T1 (n = 33) | 74.5 ± 8.7 | 77.5 ± 6.8 | 0.82* (0.67–0.91) |
| T2 (n = 33) | 73.5 ± 6.5 | 78.5 ± 6.7 | 0.71* (0.49–0.85) |
| T3 (n = 33) | 68.6 ± 5.8 | 71.4 ± 7 | 0.59* (0.31–0.77) |

* p < 0.0003.

The test of Passing Bablok shows that ScvO2 overestimates SvO2 during the 3 sample times.

**Conclusions:** ScvO2 cannot be substituted for SvO2 in cardiac surgery with cardiopulmonary bypass.

**References:**

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**A-75**

**Activated clotting time in patients undergoing cardiopulmonary bypass: evaluation of a new aprotinin-insensitive ACT test using sonoclot**

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**Background and Goal of Study:** The kaolin-based activated clotting time assessed by the HEMOCHRON system (HkACT) is a clinical standard to monitor heparin therapy alone and combined with aprotinin during cardiopulmonary bypass (CPB). However, aprotinin is known to prolong not only celite-based ACT measurements but also kaolin-based ACT (1). Overestimation of ACT implies a potential hazardous risk of subtherapeutic heparin anticoagulation and must be avoided. Recently, a so-called aprotinin-insensitive ACT test has been developed for the SONOCLOT Analyzer (SaiACT; Sienco Inc., Wheat Ridge, CO). The aim of our study was to evaluate and compare SaiACT with HkACT and anti-Xa activity in patients undergoing CPB.

**Materials and Methods:** 44 patients scheduled for elective cardiac surgery were studied. Heparin therapy was guided by HkACT. Blood samples were taken at baseline (T0), after heparin administration (200 U/kg, 100 U/kg; T1,2), on CPB, before (T3) and 15, 30, 60 min after administration of aprotinin (2 Mio KIU; T4,5,6), and after protamine infusion (T7). HkACT, SaiACT and anti-Xa activity were measured at each time point, both ACT were measured in duplicate. Statistical analysis was done using Bland-Altman analysis, linear regression with Fisher’s z-transformation and ANOVA with post-hoc Bonferroni-Dunn correction.

**Results:** A total of 352 blood samples were analyzed. Administration of heparin/protamine induced a significant increase/decrease of HkACT, SaiACT and anti-Xa. Compared to HkACT, SaiACT was significantly lower at T0–7: mean bias (SaiACT-HkACT) was −55 ± 113 sec (−11 ± 17%; p < 0.01). Correlations of HkACT-anti-Xa (r2 = 0.41) and of SaiACT-anti-Xa (r2 = 0.48) were significantly different (p < 0.01). After administration of aprotinin (T4–6) 8% of SaiACT readings were <480 sec, whereas all HkACT measurements were >480 sec. Coefficient of variation was comparable for HkACT and SaiACT (HkACT = 7.9 ± 11.6%, SaiACT = 7.5 ± 7.9%).

**Conclusion:** These data indicate that SaiACT may be a valuable alternative to HkACT for guiding heparin therapy during CPB when aprotinin is used. The use of SaiACT may result in an increased administration of heparin.

**Reference:**

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**A-76**

**Dumping coefficient and natural frequency are incomplete dynamic response parameters of pressure monitoring line**

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**Background and Goal of Study:** The dumping coefficient and natural frequency are standard parameters for anesthesiologists to evaluate the dynamic responses of pressure monitoring lines. But in fact, under the lumped constant model described by the second order ordinary differential equation the dumping coefficient can be derived from amplitude gain at
natural frequency. We demonstrated the effectiveness of the dumping coefficient and natural frequency with our high-precision frequency response measurement method (step-response analysis).

Materials and Methods: A blood pressure wave converter (Biotek 601A) connected to a function signal generator, 2 channel pressure amplifiers and personal computer were used. After introducing a square wave into the blood pressure monitoring line, proximal (input) and catheter-end (output) pressure waves were recorded with pressure amplifiers. Frequency response curves (amplitude and phase), the dumping coefficient and natural frequency were displayed after analysis with our original computer program.

Results and Discussions: There were discrepancies between dumping coefficients and natural frequencies, and frequency response characteristics.

Two curves (Fig. 1) had the same dumping coefficient (0.20). The natural frequency of the left curve (33.2 Hz) was higher than that of the right one (26.4 Hz), so the dynamic response of the left monitoring line seemed better than that of the right one. But in fact the right frequency response curve had an excellent dynamic response with a wide, flat, low frequency range and without pressure wave distortion.

Conclusion(s): The dumping coefficient and natural frequency cannot elucidate the shape of frequency response curves. Therefore these parameters became less useful for dynamic response evaluation.

A-77
Changes in cerebral oximetry during carotid endarterectomy
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Background and Goal of study: Cerebral oximetry is a simple method of measuring regional cerebral oxygen saturation or SrO2 (1). During carotid endarterectomy (CEA), carotid clamping causes a decrease in the ipsilateral SrO2 (2). The goal was to study the effect of carotid clamping on SrO2 depending on the grade of stenosis of the contralateral carotid artery.

Materials and methods: We studied 27 patients who underwent CEA under general anaesthesia. Patients were divided into two groups: contralateral carotid stenosis of less than 70% (G I), and more than 70%, severe stenosis or occlusion (G II). The INVOS-4100 cerebral oximeter was used for measuring regional cerebral oxygen saturation (SrO2) (1). During carotid endarterectomy, SrO2 was measured at several times: baseline (t1), after induction of general anaesthesia (t2), before carotid clamping (t3), one and five minutes after carotid clamping (t4 and t5), and after declamping (t6). At the same times, direct anaesthesia (t2), before carotid clamping (t3), one and five minutes after carotid clamping (t4 and t5), and after declamping (t6) were measured before and after carotid revascularization.

Results: The data of DTI in regional segment of left ventricle had been recorded successfully in 18 segments of all patients. Compared with pre and post revascularization, the peak velocities of blood flow were significantly more and the IVRT was significantly shorter after coronary revascularization. There was no significant difference in the IVCT before and after revascularization.

Conclusions: Pulse wave DTI is a feasible non-invasive technique that allows for the assessment of regionally functional performance and dynamics of the left ventricle myocardium in the intraoperative TEE examination during coronary revascularization.

A-79
Impedance cardiography: noninvasive measurement of hemodynamics and thoracic fluid content during endoscopic thoracic sympathectomy
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Background: Endoscopic thoracic sympathetic (ETS) is a minimally invasive procedure for treating palmar hyperhidrosis (PH). Hemodynamic changes occurs with CO insufflation during ETS (1,2). In the present study hemodynamic changes were examined during ETS under general anaesthesia using impedance cardiography (ICG).

Patients and Methods: 17 adult patients(15 males) scheduled to undergo elective unilateral ETS for treatment of PH were randomly enrolled in the study. Patients with cardio-respiratory disease were excluded from the study. Their age, and weight mean values were 26.5 ± 5 yr, 71.9 ± 11.5 kg respectively. Besides routine monitoring, ICG monitor was used to measure cardiac output (CO), cardiac index (CI), stroke volume (SV) and total fluid content (TFC) (3). For statistical analysis, three phases were defined for data collection: A, prior to CO insufflation, B at 10, 5 and 2 mmHg (IP), during and C, after gas deflation. ANOVA was used for statistical analysis.

Results:

<table>
<thead>
<tr>
<th>Variable</th>
<th>A</th>
<th>B10</th>
<th>B5</th>
<th>B2</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>CO</td>
<td>5.7 ± 1</td>
<td>4.5 ± 1*</td>
<td>4.8 ± 1*</td>
<td>5.4 ± 0.9</td>
<td>5.9 ± 1.1</td>
</tr>
<tr>
<td>CI</td>
<td>3.2 ± 0.4</td>
<td>2.6 ± 0.3*</td>
<td>2.7 ± 0.4*</td>
<td>3.1 ± 0.3</td>
<td>3.3 ± 0.6</td>
</tr>
<tr>
<td>SV</td>
<td>74.8 ± 18.5</td>
<td>60.8 ± 16</td>
<td>65.3 ± 17</td>
<td>66.4 ± 10.6</td>
<td>64.3 ± 18.7</td>
</tr>
<tr>
<td>TFC</td>
<td>30 ± 5</td>
<td>30.6 ± 3.9*</td>
<td>31 ± 3.4*</td>
<td>31.6 ± 3.3*</td>
<td>32.5 ± 6.8</td>
</tr>
</tbody>
</table>

*P < 0.05.

Conclusions: Significant reduction of CO, CI and SV were detected in the present study, but they were of no clinical significance. Of interest was the significant reduction of TFC during CO insufflation. Whether reduced TFC correlated to magnitude of compression, with subsequent hemodynamic changes, exeisted on the closed hemithorax by CO insufflation, yet to be further studied.

References:
A-80
Calibration method used by Colin tonometry results in significant errors in blood measurement
M. Staber, S. Hansen
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Background and Goal: Colin tonometry module provides a non-invasive alternative to intra-arterial blood pressure (BP) measurement (1). Calibration of the tonometry module relies on an oscillometric method. Our aim was to look at the effect of the calibration on module accuracy.

Materials and Methods: Ten conscious patients with an indwelling arterial catheter were studied. The Colin monitor performed ten calibration cycles firstly with the oscillometric cuff on the same arm as the tonometry module and secondly on the opposite arm. Simultaneous recording of BP wave forms from the intra-arterial BP transducer and the Colin monitor allowed comparison of beat-by-beat systolic, diastolic and mean BP.

Results and Discussions: There were considerable inter- and intra-patient variations. In the worst case, error range was 41 mmHg over ten calibrations. Analysis of variance (ANOVA) showed that contra- and ipsilateral calibrations gave a significantly different bias (P < 0.001 for systolic BP), while the multiple calibrations accounts for a significant proportion of the variability in systolic BP error (P < 0.03). The figure shows BP difference (tonometry vs intra arterial) in one patient following 10 calibrations.

Conclusions: Colin Tonometry is not accurate enough to be used with confidence in clinical practice. The main reason for this is its reliance on an oscillometric method for calibration of the tonometry module. Single BP measurements, using either manual or semiautomatic instruments, may vary considerably from the “true” blood pressure due to short-term perturbations of BP.

Reference:

A-81
Breath by breath, non-invasive measurement of cardiac output by pulmonary capnodynamics: comparison with aortic flow probe
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Background and Goals: Techniques based on the Fick principle using pulmonary gas exchange measurement are among the oldest methods for non-invasive measurement of cardiac output (Qt), but do not allow truly continuous monitoring. The capnodynamic method utilizes CO₂ elimination by pulmonary capnodynamics, to obtain systemic Qt. The theoretical basis and prototype measurements on the lungs during alternating levels of alveolar ventilation to automatically calculate Qt with each breath, and ii) the theoretical basis and prototype measurements are described in detail. Mean difference and standard deviation [sd] of the difference between capnodynamic and aortic flow probe measurements were calculated for i) Qt with each breath, and ii) change in Qt between successive 30 sec periods.

Results and Discussions: Aortic flow probe Qt varied between zero and 9.4 L/min (mean 3.9 L/min). Overall mean bias [sd] for Qt (capnodynamic – aortic flow probe) was: –0.47 [1.27] L/min; for change in Qt: 0.00 [0.51] L/min. Two cardiac arrest events were clearly identifiable by capnodynamics within 30–60 sec of occurrence.

Conclusion(s): A prototype measurement system using capnodynamics accurately tracked sudden dramatic fluctuations in Qt in real time in an animal model. The method has potential for continuous non-invasive cardiac output in patients during anesthesia and critical care.

A-82
Minimally invasive system to measure cardiovascular dynamic performance
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Background and Goal of Study: Significant haemodynamic information can be estimated by signal processing systemic arterial pressure (Pas) (1–2).

A such approach allows a more accurate monitoring during anaesthesia or in ICU without introducing new measurement lines.

Materials and Methods: The maximum value of time derivative of Pas, max (dPas/dt), has been studied in order to correlate its value to CO trends and, more generally, to obtain information on the efficiency of cardiovascular system. The study has been divided in two parts. In the first phase 86 measurements on 10 (age 75 ± 7) patients admitted to surgery for abdominopelvic aorta aneurysm in epidural anaesthesia were performed (2). max (dPas/dt) and CO were measured during different phases of the surgery. In the second part study 10 measurements on a single patient (age 42) using bi-ventricular assist circulation devices (Thoratec) VAD were performed. Here CO was settled by console controls and changes in haemodynamic parameters (including dPas/dt) were measured. For both phases the relationship between target parameters has been studied computing r (the correlation coeff. of linear regression during the experiment on a single patient).

Results and Discussions: In epidural anaesthesia the within subject correlation between max (dPas/dt) and CO measured with thermodilution method is excellent (2). In all patients r (Mean ± SD) is 0.94 ± 0.04. Therefore in epidural anaesthesia (i.e. in fixed condition of other haemodynamic parameters – SVR, HR, etc.) the CO depends essentially on the component of heart contractility given by max (dPas/dt). Conversely using bi-VAD the value of max (dPas/dt) remains constant due to the characteristics of the device. Short-term changes to consider SVR constant imposed to CO are reflected only by changes in the heart rate imposed by the control algorithms of the VAD (CO vs. HR, r = 0.93).

Conclusion: max (dPas/dt), crossed with other parameters, can be profitably used as a sign of efficiency of the cardio circulatory system.

References:

A-83
Comparison of transoesophageal echocardiography and pulse contour analysis for real-time measurement of cardiac output
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Background and Goal of Study: Continuous measurement of cardiac output (CO) is of great importance in the critically ill. However, pulmonary arterial
thermodilution has been questioned for possible complications associated with right heart catheterization [1]. Furthermore, measurements are delayed in the continuous mode during rapid haemodynamic changes [2]. To date, only ultrasound based methods and pulse contour analysis enable real time update of measurements [3]. We compared CO values obtained with transoesophageal echocardiography (TCO) with pulse contour analysis (PCCO) in patients scheduled for minimally invasive coronary artery bypass grafting.

Materials and Methods: After IRB approval, 16 patients ASA physical status II–III were enrolled in the study. Following standardized induction of anesthesia, a transoesophageal echo probe was inserted in the oesophagus and a catheter for pulse contour analysis was introduced in the right femoral artery. At 4 event related operative stages (baseline after induction of anesthesia, before clamping of the left anterior descending coronary artery [LAD], after LAD clamping and finally after clamp release) paired CO measurements were taken.

Results and Discussions: A total of 64 measurements were obtained at the different operative stages. TCO ranged from 2.9 to 8.5 liter min−1 (mean 5.6 liter min−1), and PCCO ranged from 3.3 to 7.9 liter min−1 (mean 5.3 liter min−1). CO measurements were analyzed using a Bland-Altman Plot. Bias between echocardiography derived cardiac output and pulse contour cardiac output was (mean ± 1 SD) 0.31 ± 0.81 liter min−1. Mean relative error was 12.9%, and limits of agreement were smaller than the recommended ±30% of mean CO.

Conclusion(s): Agreement between TCO and PCCO was clinically acceptable. PCCO derived CO determination therefore has proved to be a valuable tool for real-time haemodynamic monitoring.

References:
1 JAMA 1996; 276: 889-897.
2 Anesthesiology 1998; 89: 1592–1595.

A-85
Evaluation of the effect of esmolol on P wave dispersion
Department of Anaesthesiology and Reanimation, Mersin University Medical Faculty, Mersin, Turkey

Introduction: P wave dispersion (PWD), new ECG parameter, was reported as useful for presumption of atrial arrhythmias. Our aim was to evaluate the effect of esmolol on PWD and hemodynamic response.

Materials and Methods: 40 patients (ASA I–II) with acceptance of faculty ethic committee were divided into two random groups as group E (n: 30) esmolol and group P (n: 10) placebo.100 mg/10cc/2 min esmolol for group E and 10 cc 0.9% NaCl/2 min for group P were applied. Anesthesia induction was achieved for both groups with 5–7 mg topental Na, 0.1 mg/kg vecuronium bromù. ECG 50/s speed with 12 derivations was performed for all patients before drug application, 30th minute of induction and 5th minute of intubation. Heart rate, systolic-diastolic and mean blood pressure values were recorded in 1st, 3rd minutes of induction, 1st, 3rd, 5th minutes of intubation. P wave period was measured for all derivations of ECG. The difference between maximum and minimum P wave period was defined as PWD. Measurements were evaluated by a cardiologist and statistical analysis was made with t-test.

Result: There was not istatistical meaningful difference between the groups according to demographic and hemodynamic data. PWD period for group E before induction 35 ± 13 ms, 3rd min of induction 33 ± 11 ms; 5th min of intubation 29 ± 10 ms; for group P 31 ± 11 ms 3rd min of induction 36 ± 11 ms; 5th min of intubation 40 ± 6 ms. PWD values for group E in 5th min of intubation was statistically shorter compared with group P (p < 0.03).

Discussion: Compared with the control group, hemodynamic response was not different in the esmolol group. Although more evaluations are necessary for a definite decision, we believed that esmolol can be used to prevent atrial arrhythmias.

A-86
Use of a transesophageal device during orthotopic liver transplantation
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Background and Goal of Study: Optimal monitoring providing on-line information is often required in anesthesia for orthotopic liver transplantation (OLTx). The goal of this study was to compare cardiac output (CO) values obtained using pulmonary artery catheter (PAC) and a new transesophageal Doppler device (TED).

Materials and Methods: 30 patients undergoing OLTx were enrolled after an informed consent was obtained. Anaesthesia and monitoring were performed according to institutional standard, including monitoring of invasive arterial pressure and PAC. The Doppler probe (Hemosonic-Arrow) (TED) was inserted after tracheal intubation. Every time a thermodilution CO was performed, the most recent TED measurements were also recorded. After the first determination, an infusion of dopamine (3-5 mcg/Kg/min) was started. Veno-venous bypass was always used. Statical analyses were executed using Bland-Altman analysis, correlation and two-ways analysis of variance for repeated measurements.

Results and Discussions: In our patients 420 paired measurements of CO were carried out. The absolute values of CO were underestimated by Doppler technique (7.9 ± 2.46 vs 7.3 ± 2.37; p = 0.2). The systematic underestimation of CO TED with respect to CO PAC was moderate (0.631/min) and the limit of agreement (±2SD) were −1.56/L/min and 2.76/L/min. Percentage error (±2SD/mean) was ±28% (1). Aortic blood flow acceleration (Acc) and peak velocity (PV), obtained by TED, showed a significant increase after start of dopamine infusion (from 19.4 ± 7 to 30 ± 6.5, and from 73 ± 17 to 105 ± 28, respectively), and remained elevated throughout the surgical procedure.

Conclusion: TED can provide a clinically useful estimate of CO. What is important, variations of CO were comparable in time using both techniques. In addition TED may provide valuable information regarding myocardial function, such as Acc and PV which with more comprehensive hemodynamic profile would provide for better management of patients.

References:
A-87
Erroneous measurement of haemodynamic parameters by PiCCO monitor in a critically ill patient with renal replacement therapy
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Background and Goal of Study: The determination of the continuous cardiac output by PiCCO™ monitor requires periodic calibrations through a central line catheter.

Materials and Methods: A 54-year-old woman was admitted to the ICU with multiorgan system failure due to nosocomial pneumonia. Calibrations of the PiCCO™ monitor were performed through the accessory lumen of a Certofix™ Trio HF catheter (Braun) placed at the right internal jugular vein to carry out continuous venous-venous haemodialysis (CVHD). We followed the management algorithm depicted in the Figure 1A. The patient’s clinical worsening made us to perform an echocardiography that showed us a completely different clinical picture than the obtained with the PiCCO™. The CVHV-D technique was stopped, and the new obtained PiCCO™ measurements showed a different physiology, similar to that obtained by the echo (Figure 1b).

Results and Discussions: Due to the high flow of the haemodialysis catheter, there was an alteration of the area under the curve produced by the PiCCO™ monitor. The CVHV-D technique was stopped, and the new obtained PiCCO™ measurements showed a different physiology, similar to that obtained by the echo (Figure 1b).

A-88
The use of entropy in the monitoring of CNS reaction during general anesthesia
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Background and Goal of Study: It is well known that fentanyl (F) prevents haemodynamic reaction to the tracheal intubation. Less is known about the role of F on diminishing the risk of awareness. The goal of this study was to evaluate the effect of F on CNS responses during the early stage of anesthesia and tracheal intubation and to assess the informative role of EEG entropy.

Materials and Methods: 50 patients for elective gynaecological surgery, ageing 33–59 (ASA I–II) were randomised in two groups. Anesthesia was induced with midazolam 2.5 mg, propofol 2 mg/kg, atracurium 0.6 mg/kg, F 0.0025 mg/kg (group A, n = 25). Control group B (n = 25) instead of F received normal saline. Immediately after tracheal intubation sevoflurane inhalation 2 MAC was started. To measure CNS responses during induction of anesthesia and tracheal intubation the Datex-Ohmeda entropy module was used, which measured two entropy indications: the state entropy (SE) and response entropy (RE). As it is known RE indicates the patient response to external stimulus. CNS reactions and standard monitoring were performed before and after anesthesia induction, during tracheal intubation, 3 and 6 min after intubation (1–3). The data were analysed with unpaired t-test and confidence interval analysis.

Results and Discussions: In A group SE (34 ± 3) and especially RE (36 ± 2) were significantly lower than in the B group at the tracheal intubation procedure, by 11% and 22% lower correspondingly (p < 0.05). After beginning of sevoflurane inhalation the entropy value and haemodynamic parameters decreased gradually in both groups and became similar during 6 min.

Conclusion: The response entropy value during intubation of trachea confirmed, that injection of fentanyl in dose 0.0025 mg/kg was effective to suppress the CNS responses to the noxious stimulation, induced by intubation of trachea.

References:

A-89
Effect of lidocaine on hemodynamic and bispectral index responses to induction of general anesthesia and intubation
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Background and Goal of Study: Bispectral index (BIS) has been utilized to monitor hypnotic response to intubation (1), and lidocaine is used to attenuate response to intubation (2). We investigated the effect of lidocaine on the hemodynamic and BIS responses to induction of general anesthesia and tracheal intubation.

Materials and Methods: Forty patients (ASA I) were randomly allocated into two groups of twenty to receive normal saline or lidocaine 1.5 mg/kg intravenously 30 sec after induction. 90 sec later, tracheal intubation was performed. Systolic blood pressure (SBP), heart rate (HR), and BIS were measured at baseline, 1 min after induction, immediately before (pre-intubation), and every minute until 5 min after tracheal intubation.

Results: Data (Mean ± SD) are shown in the figure:

Conclusion: Lidocaine decreased BIS after induction, but did not prevent BIS increases in response to laryngoscopy and tracheal intubation.

References:

A-90
Effect of intravenous lidocaine on EEG spectral entropy and haemodynamic responses to laryngoscopy and tracheal intubation: preliminary results
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Background and Goal of Study: EEG spectral entropy can be used to monitor depth of anesthesia. We investigated the effect of IV lidocaine on entropy and haemodynamic responses to laryngoscopy (L).

Materials and Methods: After IEC approval, 20 ASA I or II consenting patients undergoing routine surgery were studied. They were randomly allocated to receive either 1 mg kg⁻¹ lidocaine (n = 10) or the same volume of saline (n = 10) before L. The event sequence was the following, each event occurring at the beginning of the 1 min non-invasive blood pressure (NIBP) measurement cycle: 0.15 μg kg⁻¹ sufentanil (L = 5 min), 2 mg kg⁻¹ propofol

References:
A-91
Is entropy a monitor for the guidance of intraoperative analgesia?
Department of Anesthesiology and Intensive Care, University Hospital, Lille, France

Background and Goal of Study: Entropy is a new method for analyzing depth of anesthesia which describes two parameters: SE (State Entropy) calculated from EEG, and RE (Response Entropy) calculated from EEG and frontal EMG. Since patients with inflammatory bowel disease (IBD) suffer from hyperalgesia in the perioperative period [1], entropy could be a good monitoring in these patients, RE being an indicator of analgesia defect. The aim of the study was to compare BIS (Bispectral Index) with entropy during laparotomy for IBD and to evaluate variations of RE and SE during nociceptive stimulation.

Materials and Methods: 14 IBD patients undergoing laparotomy were included prospectively. Anaesthesia was performed with propofol, sufentanil and atracurium. Depth of anaesthesia was adjusted to maintain BIS between 40 and 60 while sufentanil bolus was administered according to systolic blood pressure and heart rate variations larger than 20%. BIS, RE and SE were recorded at each nociceptive stimulation. ANOVA was used to assess BIS, RE and SE variations throughout surgery. P < 0.05 was considered as significant. Pearson correlation was used between BIS, RE and SE. P < 0.01 was significant. The performance of SE and RE for monitoring depth of anaesthesia and for guidance intraoperative analgesia was evaluated by constructing ROC curves.

Results and Discussions: BIS and entropy behaved similarly during anaesthesia. A significant correlation between BIS, RE and SE was observed (P < 0.01). For the performance to monitor depth of anaesthesia, area under the ROC curves (AUC) were 0.932 ± 0.26 for RE and 0.926 ± 0.27 for SE while AUC for guidance intraoperative analgesia were 0.709 ± 0.46 and 0.688 ± 0.47. Overall, the AUC were not different between RE and SE.

Conclusion(s): Both RE and SE seem to be as good as BIS for anaesthesia depth monitoring. On the other hand, additional EMG analysis with RE does not seem to bring information regarding defect of analgesia in surgery requiring neuromuscular blockers.

Reference:

A-92
Association between subjective assessment of anaesthetic depth and BIS or spectral entropy by inexperienced and experienced anaesthesiologists
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Background and Goal of Study: Many anaesthesiologists deny the need for a monitor of anaesthetic depth in clinical practice. Subjective assessment of anaesthetic depth is deemed sufficient. To test this notion, we compared subjective assessment of anaesthetic depth by experienced (>4 years of experience in anaesthesia) and inexperienced (<2 years) anaesthesiologists with EEG-based indices as surrogate parameters of anaesthetic depth.

Materials and Methods: Following IRB approval and written informed consent, 100 ASA I–II patients were assigned to either the inexperienced group (I, n = 11) or the experienced group (E, n = 14) of anaesthesiologists prospectively in order to obtain comparable values for patient age and duration of anaesthesia. Anaesthesiologists were blinded towards the EEG parameters and assessed anaesthetic depth subjectively on an 11-point numeric scale and a verbal scale (very deep – deep – light – almost awake – awake). Assessment was recorded at defined time points, starting from 2 minutes after induction until the end of surgery. Simultaneously, bispectral Index (BIS), Aspect Medical Systema) and spectral entropy of the EEG (EEG “state entropy”, M entropy module, Datex-Ohmeda) were recorded. The association between the subjective assessment and the EEG parameters was calculated using the prediction probability P0 as suggested by Smith (1).

Results and Discussions: The association (P0) of subjective assessment and BIS was significantly better in the group of experienced (P0 = 0.78) than in the group of inexperienced anaesthesiologists (P0 = 0.71). High BIS values correlated well with high SE values. Episodes of intraoperative BIS levels >60 at a verbal assessment “very deep” or “deep” were observed in 12.3% of anaesthetic cases in the experienced group and in 23.3% in the inexperienced group.

Conclusion(s): Although the association between subjective assessment of anaesthetic depth and EEG-based indices improved with experience, in both groups a high incidence of inadequately light anaesthetic states (indicated by BIS or SE values >60) was found. Subtle memory formation may be possible during such episodes (2), even though no explicit memory was recorded in our study.

References:

A-93
Sevoflurane titration by using spectral entropy or bispectral index: effects on recovery time
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Background and Goal of Study: Spectral Entropy (Response Entropy: RE; State Entropy: SE) is a new EEG based monitor of anaesthetic depth designed to assess the hypnotic effect of anaesthetic drugs. This preliminary study aimed to investigate the effect of sevoflurane titration by using Spectral Entropy or Bispectral Index (BIS) monitor on recovery time during gynecological surgery.

Materials and Methods: After approval of the Ethics Committee and written informed consent, 24 female patients ASA I–II, aged 40–60, undergoing elective gynecological surgery were randomized into two groups: BIS group (n = 12) and Entropy group (n = 12). Induction technique was standardized with propofol 2 mg kg⁻¹, fentanyl 2 μg kg⁻¹, and tracheal intubation was performed using rocuronium 0.6 mg kg⁻¹. Anaesthesia was maintained with sevoflurane and a mixture of 60% N₂O in O₂. The concentration of sevoflurane
was titrated to maintain both BIS and Entropy (RE, SE) "target values" between 40–60 during maintenance of anaesthesia and 10 min before the end of the surgery, in the range of 60–70. The end-tidal sevoflurane concentration (EtSevo, vol%), blood pressure, heart rate, the time required to "eye opening", "extubation", "response to verbal command" were recorded. Statistical comparisons were performed by unpaired T-test (statistical significance when P < 0.05).

Results: The groups were similar according to age, body mass index, duration of surgery, haemodynamic stability and mean fentanyl dosages. No clinical signs of awareness were noted and no patients had any postoperative recall. Mean (SD±) values are summarized in the table below.

<table>
<thead>
<tr>
<th></th>
<th>Entropy (min)</th>
<th>BIS (%)</th>
<th>EtSevo (vol%)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SE</td>
<td>RE</td>
<td></td>
<td>NSS*</td>
</tr>
<tr>
<td>Sevoflurane Group</td>
<td>0.65 ± 0.17</td>
<td>0.79 ± 0.12</td>
<td>3.96 ± 2.19</td>
<td>4.97 ± 2.48</td>
</tr>
<tr>
<td>Isoflurane Group</td>
<td>5.10 ± 3.56</td>
<td>7.55 ± 3.53</td>
<td>0.209 N</td>
<td>NS*</td>
</tr>
</tbody>
</table>

(NSS*: Non-Statistical Significance).

Conclusion: Titrated of sevoflurane using Spectral Entropy decreases the end-tidal concentration of sevoflurane, when compared to BIS, but does not improve patient's recovery time probably due to the favorable pharmacokinetic profile of sevoflurane.


A-94

Effects of the electric drill in accuracy of spectral entropy in tympanoplasty

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Background and Goals: The concept of spectral entropy has been recently introduced for assessing awareness. Although the algorithm has been designed to detect and remove artifacts such as electrocautery, electrocardiogram, pacers, and movement (1), some situations have not been described before, like the use of the drill in ear surgery.

Materials and Methods: We present two cases undergoing scheduled tympanoplasty under general anaesthesia with propofol and remifentanil. Non invasive arterial pressure and heart rate were recorded, and state entropy (SE) and response entropy (RE) was assessed with the Datex-Ohmeda Entropy module.

Results and Discussions: Peaks on the SE and RE lines were coincident with the temporal bone dissection using electric drill. In those events electroencephalographic records were very similar to the signal registered in the awake phase. In a first moment these changes were considered a nociceptive stimulus, so that the dose of propofol and remifentanil was increased.

A-95

Comparison of spectral entropy and BIS during sevoflurane or isoflurane anesthesia

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Background and Goal of Study: It is believed that inhalational anesthetics produce dose-dependent decrease in BIS values. However, some reports showed that the BIS values reach a plateau or show only minimal changes at a range of 1.2–1.8MAC sevoflurane/isoflurane anesthesia (1). The Datex-Ohmeda Entropy module has been developed to measure the irregularity of the EEG signal under general anesthesia. Spectral entropy provides two separate entropy indicators, namely state entropy (SE) and response entropy (RE). Here we studied the dose response relationship of SE, RE and BIS during either sevoflurane or isoflurane anesthesia.

Materials and Methods: After institutional approval and obtained informed consent, 20 patients (ASA I or II, aged 35–45 yrs) scheduled for lower abdominal surgery were included. Patients were not premedicated. After applied both the Entropy and BIS electrode probes, anesthesia was induced with 5% sevoflurane (N = 10) or 3% isoflurane (N = 10) followed by 3 μg/kg of fentanyl and 0.15 mg/kg of vecuronium. After tracheal intubation, anesthesia was maintained with 3% sevoflurane or 1.8% of isoflurane, respectively. Fentanyl and vecuronium were added in requirement. The comparative RE, SE and BIS values were measured at least 20 mins interval at the following end-tidal anesthetic concentrations.

Sevoflurane Group: 3.0, 2.5, 2.0, 1.5, 1.0, 0.5%

Isoflurane Group: 1.8, 1.5, 1.2, 0.9, 0.6, 0.3%

BIS, SE and RE were compared using one-way ANOVA followed by paired-t-test.

Results: Data are shown in the following figures.

Conclusions: In contrast to BIS, SE and RE changed in dose-dependent manner in all investigated anesthetic concentrations. Spectral Entropy would be more suitable to measure the depth of anesthesia in clinical settings.


A-96

Response entropy changes after noiceptive stimulus during general anaesthesia

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Background and Goal of Study: Entropy is a new hypnosis monitor used during general anaesthesia. It analyzes the electrocorticogram and it could give information about the arousal during the anaesthesia. The main goals of the study were to establish the standard entropy values in different sevoflurane and propofol target concentrations and the entropy response observed to painful stimulus.

Materials and Methods: Prospective, randomized study that included 10 patients ASA I scheduled for ENT surgery. The study was achieved before surgery, we divided in 2 groups: sevoflurane y propofol. Group sevoflurane, anaesthesia induction with fresh gas flow 7/min, and FiO2 100%, sevoflurane end-tidal was kept at 2%, 3% and 4%, during 15 min, each concentration. In Propofol group, we set the plasmatic concentrations calculated, with a TCI device, at 3 mcg/ml, 4 mcg/ml, and 5 mcg/ml, during 15 min each concentration.

Conclusions: In ear surgery, bone dissection using electric drill could affect accuracy of spectral entropy, with similar parameters to a decreasing depth of anaesthesia.

At each target concentration fixed we applied a nociceptive stimulus: tetanus 100 Hz, during 5 sec. In the operating room we set the standard monitoring, BIS, response entropy (ER), and state entropy (ES). Results: ER/ES at target concentrations (m ± sd):

<table>
<thead>
<tr>
<th></th>
<th>ER</th>
<th>ES</th>
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</thead>
<tbody>
<tr>
<td>Sevoflurane</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2%</td>
<td>68.75 ± 21</td>
<td>66 ± 22</td>
</tr>
<tr>
<td>3%</td>
<td>47.5 ± 12.4</td>
<td>43.75 ± 12.3</td>
</tr>
<tr>
<td>4%</td>
<td>37 ± 9.9</td>
<td>37.5 ± 7</td>
</tr>
<tr>
<td>Propofol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 mcg/ml</td>
<td>63 ± 10.4</td>
<td>58.75 ± 7.5</td>
</tr>
<tr>
<td>4 mcg/ml</td>
<td>42.25 ± 17.2</td>
<td>45.75 ± 18.7</td>
</tr>
<tr>
<td>5 mcg/ml</td>
<td>30.5 ± 11</td>
<td>32 ± 6.9</td>
</tr>
</tbody>
</table>

At target concentration, RE pre and post-tetanus stimulus, that represents ED95 we found significative differences (*p < 0.05) in both groups. ER Sevoflurane pre /post-tetanus 37 ± 9.9/45.5 ± 12.*
ER Propofol pre /post-tetanus 30.5 ± 11/38.7 ± 8. *Conclusions: On one hand we have set the entropy values at which patients are anesthetized and on the other hand the study shows significative changes in the ER values when a nociceptive stimulus is applied. Nevertheless we should increase our sample size to evaluate the liability of our results.

References:

A-97 Influence of combined drug effect with sevoflurane/remifentanil and propofol/remifentanil on prediction probability of entropy and auditory evoked response
F.D. Wagner, S. Schraag
Department of Anaesthesiology, University Ulm, Ulm, Germany

Background and Goal of Study: Validity of depth of anaesthesia parameters are less good described with drug interaction. Thus, we investigated the predictive performance of state entropy (SE), response entropy (RE) and the A-Line autoregressive index (AAI) to distinguish between different levels of consciousness during induction and recovery of anaesthesia with sevoflurane or propofol combined with low or high dose remifentanil.

Materials and Methods: With IRB approval and informed consent, forty unmedicated patients undergoing minor orthopedic surgery were randomly allocated to one of the following groups: (1) sevoflurane/remifentanil (cF = 2 ng/ml), (2) sevoflurane/remifentanil (cF = 8 ng/ml), (3) propofol/remifentanil (cF = 2 ng/ml), (4) propofol/remifentanil (cF = 8 ng/ml). During induction (loss of consciousness, LOC) and recovery of consciousness (ROC), A-Line autoregressive index (AAI) to distinguish between different levels of consciousness, BIS, response entropy (RE), and Entropy (ES) were less good described with drug interaction. Thus, we investigated the prediction probability of entropy and auditory evoked response.

Results: The table shows calculated Pr values ± SEM (Jackknife standard)

<table>
<thead>
<tr>
<th></th>
<th>AAI</th>
<th>SE</th>
<th>RE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Propofol + Remi 2 ng/ml</td>
<td>LOC 1.00 ± 0.00</td>
<td>1.00 ± 0.01</td>
<td>0.90 ± 0.09</td>
</tr>
<tr>
<td></td>
<td>ROC 0.87 ± 0.09</td>
<td>0.79 ± 0.10</td>
<td>0.89 ± 0.07</td>
</tr>
<tr>
<td></td>
<td>QAAS 0.83 ± 0.02</td>
<td>0.90 ± 0.02</td>
<td>0.91 ± 0.02</td>
</tr>
<tr>
<td>Propofol + Remi 8 ng/ml</td>
<td>LOC 0.90 ± 0.07</td>
<td>0.70 ± 0.12</td>
<td>0.67 ± 0.14</td>
</tr>
<tr>
<td></td>
<td>ROC 0.93 ± 0.06</td>
<td>0.82 ± 0.10</td>
<td>0.82 ± 0.12</td>
</tr>
<tr>
<td></td>
<td>QAAS 0.87 ± 0.02</td>
<td>0.90 ± 0.02</td>
<td>0.86 ± 0.03</td>
</tr>
<tr>
<td>Sevo + Remi 2 ng/ml</td>
<td>LOC 0.64 ± 0.12</td>
<td>0.67 ± 0.12</td>
<td>0.75 ± 0.11</td>
</tr>
<tr>
<td></td>
<td>ROC 0.94 ± 0.05</td>
<td>0.90 ± 0.09</td>
<td>0.80 ± 0.13</td>
</tr>
<tr>
<td></td>
<td>QAAS 0.80 ± 0.03</td>
<td>0.87 ± 0.02</td>
<td>0.84 ± 0.03</td>
</tr>
<tr>
<td>Sevo + Remi 8 ng/ml</td>
<td>LOC 0.68 ± 0.12</td>
<td>0.54 ± 0.13</td>
<td>0.66 ± 0.12</td>
</tr>
<tr>
<td></td>
<td>ROC 0.91 ± 0.07</td>
<td>0.60 ± 0.13</td>
<td>0.80 ± 0.10</td>
</tr>
<tr>
<td></td>
<td>QAAS 0.82 ± 0.03</td>
<td>0.82 ± 0.03</td>
<td>0.82 ± 0.02</td>
</tr>
</tbody>
</table>

Conclusion: The predictive performance of SE, RE and AAI to correctly differentiate between different states of consciousness depends on the hypnotic agent used and is negatively influenced by increasing remifentanil effect site concentrations. SE and RE better described LOC and ROC as a graded change, whereas AAI better discriminates patient state.

Reference:

A-98 Bispectral Index System (BIS): is it related to the MAC value of inhalational anesthetics?
A.H. Samarkandi
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Background and Goal of study: Bispectral Index (BIS) has been used to measure depth of sedation and anesthesia after different protocols of anesthesia. A range of BIS scores (40–60) has been seen to be an indicator for an acceptable level of hypnosis and anesthesia, independent of the drug used. Davidson and Czarnecki have recently reported that at 1 MAC the BIS for halothane was significantly greater than isoflurane 56.5 ± 8.1 vs. 35.9 ± 8.5. One of the explanations they gave for their finding is that the volume concentration of the MAC value is inversely related to the BIS value. Accordingly, it is expected that the BIS value at 1 MAC of desflurane must be less than halothane and isoflurane.

Materials and Methods: This is a clinical cross-over, prospective, randomized and double blinded study. 80 pediatric patients who were assigned for below umbilical surgery under general and caudal analgesia were allocated into 4 study groups. HI group had halothane then isoflurane, IH group had isoflurane then halothane, HD group had halothane then desflurane and the DI group had desflurane then halothane. The BIS values at 1 MAC of the previously mentioned agents were compared with each other in the same group and between other groups.

Results and Discussion: At 1 MAC, the mean BIS value for halothane 60.4 ± 5.6 was significantly higher than isoflurane 45.5 ± 9.2 and desflurane 38.5 ± 9.2 (P < 0.001). Our findings are comparable with that of Davidson and Czarnecki as regard the BIS difference between halothane and isoflurane, but in addition, the difference is much more significant between halothane and desflurane. So equivalent MAC doses of different inhalational anesthetics which are expected to prevent movement to equal noxious stimuli are not necessarily having the same effects on cortical and sub-cortical functions and consequently on EEG.

Conclusion: The use of MAC value for titration of inhalational agents may result in less or higher than the required BIS value.

Reference:

A-99 Bispectral index during propofol TCI is influenced by patients’ demographics
C.S. Nunes, D.A. Ferreira, M. Casal, L. Antunes, P. Amorim
Departamento de Matematica Aplicada, Faculdade de Ciencias, UP, Porto, Portugal

Background and Goal of Study: To our knowledge there is no published study correlating BIS with patient demography. We investigate whether BIS is influenced by age or body mass index (BMI).

Materials and Methods: Neurosurgical patients with a Glasgow 15, ASA 1/2, received TIVA with TCI propofol (Prop) and remifentanil (Remi). Data was collected using RugLoop II® software every 5 seconds from Aspect A2000XP (BIS). Effect site TCI was used with Schneider1 for Prop (initial target 5 µg/ml) and Mintz2 for Remi (initial plasma target 2.5 ng/ml). Only patients who lost consciousness with the initial target and had a maximum of 5 µg/ml effect Prop concentration, were included. Data were collected between the beginning of infusions until change in target concentrations or stimuli (induction), and maintenance of anesthesia. Statistics used linear regression (data: mean ± SD).

Results and Discussions: Twenty patients, age 47.5 ± 18, BMI 24.3 ± 6, 13 female. Duration was 262 ± 128 min. Remi and Prop predicted effect concentrations during maintenance were 3.14 ± 0.93 ng/ml and 3.52 ± 0.74 µg/ml, respectively. A positive correlation was observed between age and BIS minimum value at induction (p < 0.05). During the maintenance phase a positive correlation was also observed between BMI and median BIS (p < 0.05).

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Conclusion(s): For the same effect predicted propofol concentration older patients had a higher BIS at induction. The higher the BMI the higher the median BIS during maintenance. These findings were unexpected. It is possible that the pharmacokinetic1 model is not adequately adjusted to age, or age interferes with the Prop pharmacodynamics.

References:
1 Anesthesiology, 1998, 88:1170-82.

Acknowledgements: Portuguese Foundation for Science and Technology

A-100
Comparison of 2 pharmacodynamic EEG models with and without a pharmacodynamic plateau
S. Kreuer, J. Bruhn, U. Grundmann, E. Walter, R. Larsen, W. Wilhelm
Department of Anaesthesiology and Intensive Care Med, University of Saarland, Homburg/Saar, Germany

Background: The Bispectral index (BIS XP, Aspect, USA) can be used as an electroencephalographic measure of drug effect. We compared 2 different techniques of modeling the sevoflurane drug effect.

Methods: We investigated 26 adult patients scheduled for radical prostatectomy. After lumbar epidural catheterisation, patients received remifentanil and propofol solely for induction of anaesthesia. Thereafter, epidural analgesia was initiated, and sevoflurane was added to maintain unconsciousness. At least 45 min later, end-tidal sevoflurane concentrations were varied between 1 and 4 vol% and BIS values were recorded. To evaluate the sevoflurane-BIS relationship two different pharmacodynamic models were applied: A conventional model #1 with a single sigmoidal curve, and the novel model #2 with two sigmoidal curves for BIS values with and without burst suppression. Both models were calculated by NONMEM V (GloboMax, Hanover, USA) in one step by minimizing log likelihood. Statistical significance between the two models was calculated by the likelihood ratio test.

Results: The k0 value of the population fit including the plateau effect derived from the BIS was 0.24 min⁻¹ versus 0.27 min⁻¹ for the single curve model. The difference between the log likelihood values was 396 (P < 0.001).

Conclusion: A two sigmoidal curves PK/PD model including a plateau describes the pharmaco-dynamic effects of sevoflurane on BIS better than a single sigmoidal curve model.

A-101
Impact of patient temperature on BIS values during cardiac surgery
Department of Anaesthesiology and Intensive Care Med, University of Saarland, Homburg, Germany

Background: Hypothermia influences the level of consciousness, and this may have impact on depth of anaesthesia monitoring. We investigated the influence of hypothermia on BIS (BIS XP, Aspect, USA) when deep hypothermic cardiac arrest (DHCA) was applied during cardiac surgery with extracorporal circulation (ECC).

Methods: With IRB approval 11 adult patients undergoing DHCA were studied. After induction of anaesthesia with etomidate, propofol 4 mg/kg/h and sufentanil 1.5 μg/kg/h were given for maintenance. BIS values, pharyngeal (pha) and rectal (rec) temperatures were recorded. During DHCA propofol and sufentanil infusion were stopped. Data are mean ± SD; SigmaStat and SigmaPlot (SPSS, Germany) were used for non-linear regression analysis.

Results: BIS and corresponding temperature values were:

<table>
<thead>
<tr>
<th>Temperature (°C)</th>
<th>BIS Index</th>
<th>BIS rec</th>
<th>BIS pha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Start ECC</td>
<td>36.3 ± 5.7</td>
<td>36.3 ± 0.7</td>
<td>36.3 ± 0.7</td>
</tr>
<tr>
<td>Start DHCA</td>
<td>12.6 ± 7.5</td>
<td>20.8 ± 1.7</td>
<td>24.2 ± 2.6</td>
</tr>
<tr>
<td>End DHCA</td>
<td>4.7 ± 9.8</td>
<td>21.1 ± 2.2</td>
<td>24.4 ± 2.3</td>
</tr>
</tbody>
</table>

The regression analysis for all patients is shown in the figure (R = 0.88).

Conclusion: Temperature has an influence on the BIS: During propofol-sufentanil-anaesthesia, the relationship may be described as a mean BIS reduction of 2 points per 1°C drop, especially for the range of 22–30°C pharyngeal temperature.

A-102
Subanaesthetic dose of ketamine during propofol anaesthesia increases BIS in a dose depended manner
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Department of Anaesthesia, G. Gennimatas General Hospital, Thessaloniki, Greece

Background and Goal of study: Ketamine an old anaesthetic agent, the sole with analgesic properties, induces analgesia even in subanaesthetic dose with negligible side effects.1 The aim of this study was to evaluate the impact of such low doses of ketamine on the bispectral index (BIS), when it is administered during general anaesthesia with propofol.

Materials and Methods: We studied 40 ASA I and II patients undergoing abdominal procedures. Anaesthesia was maintained in all patients with 60% N2O in O2 and continuous infusion of remifentanil and propofol in order to keep the BIS value stable in the range of 40 ± 5. Rocuronium was administered as relaxant according to patient's needs. The patients were randomly assigned to receive IV either ketamine 0.15 mg·kg⁻¹ (Group K0.15) or ketamine 0.30 mg·kg⁻¹ (Group K0.30) after a period of stable BIS for 5 minutes. BIS values were recorded before (control) and after 1, 5, 10, 15 minutes of ketamine administration. The value BISmax-BISc (Δmax) was also calculated. Statistical analysis was performed with 2-way ANOVA and t-test with p < 0.05 as level of significance.

Results: Demographic data were similar in both groups. There was an increase of the BIS values in both groups, which seems to be significantly...
A-103
Remifentanil decreases BIS, an effect independent of intubation and surgical stimuli

Departamento de Matemática Aplicada, Faculdade Ciências, UP, Porto, Portugal

Background and Goal of Study: Remifentanil (Remi) boluses are used in various clinical situations. Several studies addressed the effect of Remi on BIS at different Remi concentrations. However, the effect of a Remi bolus on BIS under propofol (Prop)-Remi anaesthesia without surgical stimuli has not been studied.

Materials and Methods: Neurosurgical patients received a 2 μg/kg Remi bolus under TIVA in a period free from surgical stimuli. BIS was measured during the whole study. Spectral analysis of heart rate variability (HRV) at the different depth of hypnosis, and 2) to compare the effects of anesthetics on HRV.

Conclusion(s): Remi, a 2 μg/kg bolus given under Prop/Remi anaesthesia in a period free from surgical stimuli, decreased BIS, heart rate and blood pressure. This effect on BIS has not been previously shown.

References:

A-104
The influence of muscle-relaxants on BIS values in the patients during laparoscopic cholecystectomy

G. Michalska-Krzanowska, T. Zrodlowski
Department of Anaesthesia and Intensive Care, Hopital Centrale Nancy, Nancy, France

Background and Goal of Study: The electromyographic activity can elevate the bispectral index (BIS) values (1). Remifentanil and N2O were showed to not affect the BIS (2,3).

The aims of this study were to evaluate the accuracy of BIS readings in remifentanil, N2O anesthesia and the influence of muscle-relaxant administration on BIS values in patients during laparoscopic cholecystectomy.

Materials and Methods: After written informed consent, thirty volunteers ASA I or II were anesthetized with remifentanil continuous infusion 0.3 μg/kg/min throughout the whole procedure. Propofol was used for induction. Simultaneously patients received 60% N2O in oxygen via a mask to the end of anesthesia. After the loss of consciousness and before the administration of atracurium 0.5 mg/kg, a tourniquet was inflated on the right arm 150 mmHg above the systolic blood pressure to detect any gross movements during abdominal laparoscopic surgery to exclude insufficient hypnosis and/or insufficient analgesia. Every time when BIS was above 65, patients were asked to squeeze the investigator's hand every 30 s. The train-of-four sequence was monitored continuously throughout the hole procedure. Bolus of atracurium 0.15 mg/kg was repeated every time when TOF > 40%. The BIS values were measured during the whole study.

Results: While twitch recovered to 40%, BIS elevated to 83 ± 8°. The pure administration of atracurium 0.15 mg/kg significantly decreased BIS values to 69 ± 7°. None movement of the isolated arm was seen in the study patients.

A-105
Effects of anesthetics on BIS and heart rate variability

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Department of Anesthesiology, Sapporo Medical University School of Medicine, Sapporo, Japan

Background and Goal of Study: Anesthetics are known to alter both sympathetic and parasympathetic tone, however, it is not clear whether the changes in heart rate variability (HRV) is associated with the depth of anesthesia. The purposes of the present study were 1) to evaluate the changes in HRV at the different depth of hypnosis, and 2) to compare the effects of anesthetics on HRV.

Materials and Methods: Patients (n = 45) were randomly allocated into the thiopental, propofol or sevoflurane for induction of anesthesia. The depth of hypnosis was monitored by the Bispectral index (BIS). Spectral analysis of HRV resulted in two main regions, a high frequency (HF) and a low frequency (LF). Hemodynamics, entropy, LF, HF, and LF/HF were monitored at awake and after the induction of anesthesia.

Results and Discussions: Thiopental increased HR in a BIS-dependent manner, whereas blood pressure (BP) showed no significant changes. Both propofol and sevoflurane decreased BP in a BIS-dependent manner, whereas HR showed no significant changes. Thiopental decreased HF, entropy and LF with a reduction in the BIS value. LF/HF showed no significant change during the study period. Propofol decreased entropy and HF with a reduction in the BIS value. Although LF decreased after the induction of anesthesia, propofol caused no further decrease in LF. Sevoflurane decreased LF with a reduction in the BIS value. Entropy and HF decreased after the induction of anesthesia, however, no further decreases were observed in spite of a reduction in the BIS value.

Conclusion: In conclusion, anesthetics have differential effects on HRV depending on the depth of hypnosis.
A-106
Effects of 0.2% and 1% epidural ropivacaine on bispectral index during propofol anaesthesia
S. Sakura, A. Shido, T. Nomura, H. Kushizaki, Y. Saito
Department of Anaesthesiology, Shimane University School of Medicine, Izumo City, Japan

Background: Patients receiving combined epidural-general anaesthesia may be at risk of insufficient depth of anaesthesia. Although it has been shown that the bispectral index (BIS) can predict depth of anaesthesia in patients receiving combined epidural-general anaesthesia has not been examined. In this study, we compared the effects of 0.2% and 1% epidural ropivacaine on BIS during propofol anaesthesia at three clinical end-points; loss of consciousness and no response to noxious stimulation within and beyond the level of sensory block.

Materials and Methods: With IRB approval and informed consent, 35 ASA I patients undergoing lower abdominal surgery were randomly divided into two groups to receive epidural 0.2% (group 1) or 1% ropivacaine (group 2). After the upper dermatomal level of loss of cold sensation was determined, a target-controlled infusion of propofol was started to provide a blood concentration of 3 μg/ml, and increased by 0.5 μg/ml every 60 s until all three clinical end-points were reached as follows: 1) when patients lost consciousness; 2) when patients failed to show papillary dilation (PD) to tetanic electrical stimulation (TES) that was applied to the upper sensory level; 3) when they failed to show PD to TES that was applied to C5. BIS were recorded at each end-point and compared between the two groups. P < 0.05 was considered significant.

Results: BIS value at every end-point was significantly smaller in group 1 than in group 2.

Table. Bispectral Index Values at Three End-points.

<table>
<thead>
<tr>
<th></th>
<th>Group 1</th>
<th>Group 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of consciousness*</td>
<td>67.5 ± 18.7</td>
<td>73.8 ± 15.7</td>
</tr>
<tr>
<td>No response at upper level*</td>
<td>32.7 ± 10.8</td>
<td>40.7 ± 12.0</td>
</tr>
<tr>
<td>No response at C5*</td>
<td>19.6 ± 9.6</td>
<td>29.4 ± 8.4</td>
</tr>
</tbody>
</table>

Mean ± SD. *P < 0.05 between groups.

Conclusion: Our results suggests that BIS can be useful to detect cerebral ischemia. Nevertheless, These are the preliminary results, because more patients are needed to obtain sufficient statistic power for evaluation of sensitivity and specificity of BIS for this indication.

References:

A-108
Number of skin conductance fluctuations correlate better with signs of clinical stress during tracheal intubation than response entropy
A.C. Gjerstad, H. Storm, R. Hagen, M. Hiku, E. Qvigstad, J. Raeder
Rikshospitalet University Hospital, Skills Centre, Oslo, Norway

Background and Goal of Study: Number of skin conductance fluctuations (NFSC) in the palmar surface correlates well with sympathetic nerve activity. State Entropy (SE) measures the EEG signal, while Response Entropy (RE) measures both EMG and EEG in the forehead. In deep anesthesia both NFSC and a sudden change in RE-SE have been proposed to measure pain responses. The purpose of the study was to examine if NFSC and RE-SE correlate with signs of clinical stress during endotracheal intubation.

Materials and Methods: 20 patients were studied during tracheal intubation. Remifentanil, propofol and cisatracur were given. If the patient had systolic arterial pressure of more than 130 mmHg, movement of large muscles, tears, cough, opening of eyes, sweating in forehead or face muscle reaction, 1 point of stress was assigned for each of these reactions, adding all together to a total stress score. The stress was monitored during tracheal intubation and 60 sec afterwards. Simultaneously the maximum NFSC response and RE-SE was registered blindly. A linear regression analysis was performed between the NFSC, RE-SE and the total stress score. In awaken patients RE is usually significantly higher than SE. We therefore performed the linear regression analysis in the patients separately for all SE levels and those with SE < 70.

Results and Discussion: Clinical stress was observed in 9 of the 20 patients. The NFSC increased during intubation in all these patients and in two others, and the magnitude of increase correlated well with the stress score, r² = 0.73, P = 0.000. The RE-SE value increased >10 in 5 of the 9 patients that showed stress and in two others. The RE-SE correlated with the stress score in all the patients r² = 0.33, P = 0.007. Interestingly, when studying the 15 patients with SE < 70, 4 of these showed clinical stress. The increase in NFSC correlated well with the stress score, r² = 0.72, P = 0.000. Different from the RE-SE r² = 0.14, P = 0.15 in these 15 patients.

Conclusion: These results show that NFSC is a better measure of discomfort during tracheal intubation than the RE-SE value. If the RE-SE value increase when SE is higher than 70, this response may indicate a wake up situation.

A-109
Increase in skin conductance variables versus increase in State entropy and Response entropy during emergence after surgery in general anaesthesia
A.C. Gjerstad, H. Storm, R. Hagen, M. Hiku, E. Qvigstad, J. Raeder
Rikshospitalet University Hospital, Skills Centre, Oslo, Norway

Background and Goal of Study: Skin conductance level (SC) and number of fluctuations in skin conductance (NFSC) in the palmar surface is well correlated with sympathetic nerve activity. During emergence after surgery in general anesthesia, changes in SC and NFSC increase. Response entropy (RE) measures the combined EEG and EMG signal in the forehead, whereas State entropy (SE) measures the EEG signal only. The purpose of the study was to compare the changes in SC, NFSC, SE and RE during emergence after surgery.

Materials and Methods: 20 patients were studied during emergence after laparotomy. Remifentanil and propofol were given for general anaesthesia during surgery and fentanyl was given before emergence. SC, NFSC, the SE index and the RE index were measured continuously during emergence. The time of extubation was chosen from clinical criteria at the discretion of the anaesthesiologist and designated as the time of emergence, time = 0 (T0). A positive value was given for first signs of emergence before T0, a negative value for first signs after T0. The emergence for SE and RE were tested for two time points, when the indexes were 70 or 80. For skin conduction the emergence was defined: 2 or more fluctuations per 15 sec together with an increase in the SC of at least 0.1 microsiemens within 15 sec. The registration
lasted for 1 min after extubation. The time intervals for the skin conductance variables and SE and RE were compared using Wilcoxon non-parametric test.

Results and Discussion: Signs of emergence were not different (median, range) for skin conductance variables (14, 27–63) when compared with SE 70 (0.5, 0–278) or SE 80 (median 8, 0–252), respectively P = 0.10 and P = 0.96, different from when compared with T20 and T21 (median 45, 58–268) or RE 80 (median 33, 1–270), respectively P = 0.005 and P = 0.028. In 1 case the skin conductance variables did not increase within 1 min after extubation and in another case the SE 70, SE 80 and RE 80 was not reached. The emergence % to T0 for the skin conductance variables, SE 70, SE80, RE 70, RE 80 were respectively 80%, 85%, 90%, 90%.

Conclusion: RE 70 and RE 80 react significantly before the skin conductance variables, SE 70 and SE 80 during emergence after surgery.

A-110
Number of skin conductance fluctuations increase in a quantitative manner during tetanic pain stimuli whereas response entropy is non-reactive
A.C. Gjerstad, H. Storm, R. Hagen, M. Huiku, E. Ovgistad, J. Ræder
Rikshospitalet University Hospital, Skills Centre, Oslo, Norway

Background and Goal of Study: Number of skin conductance fluctuations per sec (NFSC) in the palmar surface correlates well with sympathetic nerve activity. State Entropy (SE) measures disorders in the EEG signal, while Response Entropy (RE) measures both EMG and EEG activity in the forehead. Both NFSC and RE-SE have been proposed to measure pain response. The purpose of the study was to examine if NFSC and RE-SE could detect pain response from tetanic stimuli, and to further examine if the tetanic stimuli response was stronger in a situation without analgesia infusion compared to a situation with ongoing analgesic infusion.

Materials and Methods: 20 patients in ASA group 1 or 2 were studied after induction of general anaesthesia with propofol, remifentanil and cisatracur, but before start of laparotomy. The patients were given 2 series of tetanic stimuli of 50 mA: Tetanic 1 (T1) with ongoing remifentanil analgesic infusion and Tetanic 2 (T2) after 4 min without analgesic infusion. The RE-SE and NFSC responses were registered continuously, starting 30 sec before stimuli and ending 30 sec after the stimuli started. The maximum values for NFSC and RE-SE during the tetanic pre stimulus periods were compared with the maximum values of the tetanic post stimulus periods. Moreover, NFSC and RE-SE responses during T1 were compared with the responses during T2. The Wilcoxon non-parametric test was used.

Results and Discussion: The NFSC pre stimulus level with median = 0 (range 0–0.02) was lower than the post stimulus level in 16 out of 20 patients with median = 0.02 (range 0–0.7) (P < 0.001). NFSC T1 response was significantly lower than the NFSC T2 response (P = 0.002). The RE-SE pre stimulus level with median = 2.0 (range 0.5–11.0) was not different from the post stimulus level with median = 1.5 (range 0.5–4.5) (P = 0.442), neither was the T1 response different from the T2 response (P = 0.20).

Conclusion: In contrast to the RE-SE, the study showed that NFSC is sensitive to tetanic pain stimuli, and the measured response is attenuated when an ongoing analgesic infusion is given.

A-111
State index of nociception correlates both with remifentanil concentration and level of painful stimulation during surgery
A. Yi-Hankala, M. Rantanen, I. Korhonen, M. van Gils, H. Yppärilä, M. Huiku, M. Kymäläinen, P. Takala, K. Uutela, H. Viertio-Oja
Department of Anaesthesia, Tampere University Hospital, Tampere, Finland

Background and Goal of Study: Today, no numeric measures of nociception during general anaesthesia are available. In search of such readily usable measure both predictive characteristics of the drug effect and responses to surgical stimulation are needed. We altered the analyses of photoplethysmographic waveform amplitude (PPGA) and heart rate (HR) during changing surgical stimuli and different target site levels of remifentanil. Our purpose was to develop a State Index of Nociception (SN) based on PPGA and HR derived information, which could measure the adequacy of analgesia during general anaesthesia and surgery.

Materials and Methods: Physiological parameters were measured from 53 female patients anaethetised with propofol and remifentanil, and paralysed with rocuronium. Remifentanil target site concentration was adjusted to 1, 3, or 5 ng/ml during surgery. SN was developed to explain the combination of analgesia during general anaesthesia and surgery. For monitoring of nociception a multi-parameter approach may be needed (1). We studied the relation between physiological responses and concentration of remifentanil (Rem) at nociceptive stimuli in anaesthetised and paralysed patients.

A-113
Mid-latency auditory evoked potentials monitor (AEP) and brain death
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Department of Anaesthesiology and Intensive Care, Hospital Clínico Universidadario Valencia, Valencia, Spain

Background and Goal of Study: Brain death (BD) is a catastrophic physiologic event associated with significant disturbances in the function of other organs. Even with maximum support, deterioration in cardiorespiratory function leading to asystole usually occurs. We have evaluated mid-latency auditory evoked potentials (AEP; Alaris Medical Systems, Hampshire, UK) values (A-AEP INDEX or AAI) in a brain death diagnosed patients.

Materials and Methods: This is a prospective, nonrandomized, observational study in a surgical and trauma tertiary intensive care of a university hospital. After approval of the hospital’s research committee, six consecutive patients (age range 17–75 yrs, mean age 47 yrs) diagnosticated of brain death during 2004, but without brain death at the time of admission were studied. AAI was recorded continuously during the hospitalization in the ICU. This study was observational and in no way interfered with our routine management of brain dead patients. The A-AEP uses headphones and 3 electrodes, 2 on the forehead and one at the mastoid.

Results and Discussion: In each of six patients when were diagnosticated of brain death (clinically and confirmed by EEG or evoked potentials, according to the Spanish legislation guidelines for assessing brain death) their individual AAI values were 0 (Tase supression of 100).

Conclusions: Because brain death causes severe cardiovascular, hormonal, and metabolic changes, its early diagnosis is crucial in terms of maintaining organ function. Thus, the early diagnosis of brain death is the first step in successful donor management. Prompt treatment to preserve organ function increases the chances of successful organ transplantation. To improve the identification of brain death patients in the ICU we can use the AAI. We think is a noninvasive determination, easy to interpretate and rapid. Anyway, the diagnosis of brain death is based on clinical examination, but we hypothetize that this could be a very useful method for early detection of neurological worsening even brain death.

A-114
Response index of nociception correlates both with remifentanil concentration and level of painful stimulation during surgery
M. Rantanen, A. Yi-Hankala, I. Korhonen, M. van Gils, H. Yppärilä, M. Huiku, M. Kymäläinen, P. Meriläinen, K. Uutela, H. Viertio-Oja
Department of Anaesthesia, Tampere University Hospital, Tampere, Finland

Background and Goal of Study: No numeric measures of nociception during general anaesthesia exist. For monitoring of nociception a multi-parameter approach may be needed (1). We studied the relation between physiological responses and concentration of remifentanil (Rem) at nociceptive stimuli in anaesthetised and paralysed patients.

Results and Discussion: SN correlated positively with stimulation (median r = 0.42, P < 0.0001) and negatively with remifentanil level (median r = −0.33, P < 0.0001). Median correlation with their difference was 0.50 (P < 0.0001). High SN values indicated presence of noxious stimuli and low remifentanil levels (figure).
Materials and Methods: 55 females were anaesthetised with propofol (Pr)–Rem target controlled infusions (TCI). Pr was given to maintain EEG State Entropy (SE) at 35–60. Rem TCI was randomised to 1, 3, or 5 ng/mL. Responses to tetanic stimulation of the ulnar nerve (30 s) were studied before surgery in a subgroup of 23 patients. Responses to skin incision were analysed in all patients. Comparison of responses in photoplethysmographic wave amplitude (PPGA), ECG beat-to-beat interval (RRI), and Response Entropy (RE) at different Rem levels was done using the Kruskal–Wallis H test.

Results and Discussion: RRI (p = 0.00001) and PPGA (p = 0.009) responses to tetanic stimulus differed significantly between Rem levels, while for the incision RRI (p = 0.019), RRI SD1 (p = 0.019) and RE–SE (p = 0.018) responses were different. A Response Index of Noiccienception (RN), developed by combining RE, RRI and PPGA variability, was significantly higher in the low doses of Rem as compared with the higher doses for both tetanic stimuli (p = 0.00005) and skin incision (p = 0.00003) (figure).

Conclusions: In paralysed patients anaesthetised with propofol–remifentanil infusions: 1) Combination of information from RE, PPGG, and RRI provides promising quantification of responses to abrupt noxious stimuli; 2) Long-lasting 30 sec tetanic stimulus induces qualitatively similar physiological responses as skin incision.

Reference:

A-115
Continuous BIS-EEG monitoring to assess evolution in depth of sedation in critically ill patients
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Introduction: The Bispectral Index (BIS) is a processed EEG parameter that has been validated as a measure of sedative-hypnotic effects of anesthetic drugs. Besides, BIS was also reported to correlate quite well with the level of pharmacological sedation in ICU patients. The aim of the present study was to evaluate the evolution over time of BIS in sedated ICU pts.

Materials and Methods: 14 ventilated surgical ICU pts, without any central neurologic disease were monitored. Pts were sedated for at least 5 consecutive days (the max was 10 days). Propofol (0.5–3 mg/kg/hr) and piritramide (0.05–0.15 mg/kg/hr). Administration of sedatives was titrated to clinical reaction of pts and was aimed at maintaining a maximal Ramsay Sedation Score. In all pts, BIS, using BIS-XP 4.0 algorithm, was continuously monitored and was blinded to ICU nurses and physicians.

Results: Already after start of sedation, we observed a wide range of BIS between 20 and 88 between these 14 pts. In 4 pts, statistical analysis (Spearman analysis) revealed no correlation between dosages of both sedatives and BIS. In 10 of 14 pts, we observed a significant decrease in BIS over time, correlated to increased dosages of both sedatives. In these 10 pts, mean BIS after start of sedation was 68 (±7), while at day 3 and at day 5 we found significantly lower BIS values (45; ±7 and 31; ±9).

Conclusion: In some pts, daily BIS monitoring might become very useful to titrate sedation of ICU patients and to prevent oversedation with possible implications as to quality of ICU management. However, as was already reported (1), BIS monitoring is not suitable for monitoring the sedation in all ICU patients.

Reference:

A-116
Bispectral index variations during tracheal suction in mechanically ventilated critically ill patients
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Introduction: The Bispectral Index (BIS), a processed EEG derived parameter, was reported as a useful indicator of depth of sedation. In ICU pts, noxious stimuli, such as tracheal suction, often result in abrupt rises in arterial pressure and/or tachycardia. The aim of this observational study was to evaluate whether BIS monitoring revealed any arousal of consciousness during these periods of noxious stimulation, in adequately sedated pts, as referring to clinical scoring systems.

Materials and Methods: We randomly monitored 30 periods of noxious stimulation (ET aspiration) in 8 ventilated surgical ICU patients who were sedated for more than 48 hr with propofol (1.5–3 mg/kg/hr) and piritramide (0.07–0.17 mg/kg/hr). In all patients, sedatives were titrated to a maximal Ramsay Sedation Score (RSS of 6) before stimulation. All pts were monitored for a standardized 60 min period (with stimulation at 30 min). Correlation between BIS (BIS-XP 4.0), RSS and hemodynamic parameters (arterial blood pressure, heart rate) before and after stimulation was analysed with Anova test.

Results: BIS values (before stimulation) varied between 20 and 74, while all pts revealed a RSS of 6. For all 30 periods, we found no significant difference in BIS and in RSS, before, during and after tracheal suction, while we found a significant increase in systolic blood pressure (and a nonsignificant increase in heart rate). In 3 of the 30 periods, we noticed a significant increase in BIS (towards values above 90). In these 3 periods, BIS before stimulation was significantly higher (64 ± 7) than BIS observed in the other 27 periods (48 ± 9).

Conclusions: Hemodynamic reactions to tracheal suction in ICU pts are not solely explained by arousal. However, in some pts BIS monitoring might be valuable in determining the level of consciousness prior to noxious stimuli, thereby avoiding arousal.

A-117
Can BIS provide any information in sedated ICU patients suffering from acute neurological injury?
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Introduction: Referring to its role in monitoring the hypnotic part of anesthesia, BIS has been introduced as an objective assessment of sedation in critically ill patients without any neurological insult. Indeed, as BIS represents a processed variable derived from the raw EEG, any underlying neurological deficit might influence its value. Therefore, we evaluated whether BIS monitoring, applied during the first 24 hrs after admission, could have any prognostic (as to neurological outcome) value in comatose sedated patients arriving to the ICU department.

Materials and Methods: Over a 12 months period, 26 adult patients with a GCS lower than 8 admitted to our hospital were included. Of these 26 pts, 14 pts suffered from a severe head injury, 7 from intracerebral bleeding and 5 from severe stroke. All pts were ventilated and were sedated with propofol (1.5–2 mg/kg/hr). In all pts, BIS monitoring was applied for a 2 hrs period during the first 24hrs of admission. Afterwards, BIS data were correlated to Glasgow Outcome Scores.

Results: Overall, a wide range of BIS values was observed (7 to 81). In 3 of 26 pts extreme low BIS values (<15) were observed, in 6 pts BIS was between 20 and 40, in 10 pts BIS was between 40 and 60, whereas in 7 pts BIS was higher than 60. Immediate neurological outcome in the 3 pts with BIS below 15 was clearly different from the other pts, as these 3 pts were declared brain dead within 24 hrs of admission. In 2 of these pts, BIS values decreased to 0 during the monitoring period, which confirmed brain death. We found no correlation between BIS values and outcome in the other pts. In the 6 pts with BIS between 20 and 40 no correlation could be found with neurological outcome, as these pts did not reveal a worsened outcome compared with pts that revealed BIS values higher than 40. And we could not observe a better outcome in those 7 pts with BIS values higher than 60.

Conclusion: The finding of extreme low BIS values in sedated pts early after a neurological insult may reveal an extreme bad prognosis. In these conditions, BIS could also be used as an assessment of brain death onset.

A-118
Fractal dimension – a new EEG-based method of assessing depth of anesthesia in comparison with BIS during induction and recovery from anesthesia
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Background and Goal of Study: Due to the nonlinear, non-stationary and fractal nature of brain activity, we have employed fractal dimension method,
adapted from Nonlinear Dynamics, to analyse EEG signals. Fractal dimension (FD) is a fast, simple and efficient technique of analysing complex signals which has already been tested in EEG analyses [1] but which has not previously been applied to anaesthetised patients. The aim of the study was to determine the accuracy of FD in comparison with BIS during induction and recovery from anaesthesia.

Materials and Methods: After ethics committee approval, 30 patients were studied, under general anaesthesia. Anaesthesia was induced with fentanyl, midazolam and propofol, titrated according to the BIS value. The raw, unfiltered EEG signal sampled at 128 Hz and the processed EEG derivatives: Bispectral Index (BIS), Burst Suppression Ratio (BSR) sampled every 10 s were recorded with an A-2000 XP BIS Monitor using BSA for BIS software (version 3.2.2B2 for A-2000). The study was performed during induction and reversal of anaesthesia. FD was calculated off-line and the results were averaged every 10 s from epochs 30 s long. The correlation method (Pearson or Spearman) was used for statistical analysis. The results are presented as a correlation coefficient (r).

Results and Discussions: Changes in FD are well correlated with BIS behaviour during induction (r = 0.81; p < 0.001) and recovery from anaesthesia (r = 0.76; p < 0.001). The table presents the percentage of: almost perfect (1), very high (2), high (3) and poor (4) positive correlation between FD and BIS during both induction and recovery from anaesthesia.

<table>
<thead>
<tr>
<th>r value</th>
<th>Induction – n (%)</th>
<th>Recovery – n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0.9 &lt; r &lt; 1</td>
<td>13 (43.3%)</td>
</tr>
<tr>
<td>2</td>
<td>0.7 &lt; r &lt; 0.9</td>
<td>12 (40%)</td>
</tr>
<tr>
<td>3</td>
<td>0.5 &lt; r &lt; 0.7</td>
<td>2 (6.7%)</td>
</tr>
<tr>
<td>4</td>
<td>r &lt; 0.5</td>
<td>3 (10%)</td>
</tr>
</tbody>
</table>

Conclusion: These preliminary results show a very high correlation of FD with BIS, an already accepted measure of hypnosis during anaesthesia. Therefore we conclude that our new, relatively simple method seems to be very promising in monitoring the depth of anaesthesia.


A-119

Dose-response relationship between sevoflurane concentrations and Narcotrend or bispectral index

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Background: The Narcotrend monitor (MonitorTechnik, Germany) is designed to measure the depth of anaesthesia. We compared the PK/PD parameters of sevoflurane based on Narcotrend or bispectral index (BIS XP, Aspect, USA) during combined epidural/general anaesthesia.

Methods: We investigated 26 adult patients scheduled for radical prostatectomy. After lumbar epidural catheterisation, patients received remifentanil and propofol solely for induction of anaesthesia. Thereafter, epidural analgesia was initiated, and sevoflurane was added to maintain unconsciousness. At the onset of burst suppression were 0.65 vol% for BIS and 0.62 vol% for Narcotrend. The C50 values for burst suppression were higher than those for induction and reversal of anaesthesia. During induction, sevoflurane was infused at a constant rate of 0.2 μg/kg/min whereas sevoflurane in 1.5/min O2/air was adjusted according to EEG target values or clinical parameters: during maintenance of anaesthesia to a value of 60” (Narcotrend) or 50” (BIS), 15 min before the end of surgery to “70” (Narcotrend) or “60” (BIS), whereas in the standard protocol group sevoflurane was controlled according to clinical parameters, e.g. heart rate, blood pressure, movements. Recovery times and sevoflurane consumption were recorded by a blinded investigator. The sevoflurane vaporiser was weighed before and after anaesthesia and mean remifentanil dosages.

Results: The groups were comparable for demographic data, duration of anaesthesia and mean remifentanil dosages.

A-120

Narcotrend or BIS monitoring during sevoflurane-remifentanil anaesthesia – a comparison with a standard practice group

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Background: The BIS monitor (BIS-XP: Aspect, USA) is currently the standard device used to assess the depth of anaesthesia. The dimensionless Narcotrend index (MonitorTechnik, Germany, version 4.0) from 100 (awake) to 0 is based on EEG pattern recognition. This study was designed to investigate the impact of Narcotrend or BIS monitoring on recovery times and sevoflurane consumption when compared to standard anaesthetic practice.

Methods: With IRB approval and written informed consent 120 adult patients scheduled for minor orthopaedic surgery were randomised to receive a sevoflurane-remifentanil anaesthetic controlled either by Narcotrend or by BIS or solely by clinical parameters. Anaesthesia was induced with 0.4 μg/kg/min remifentanil and 2 mg/kg propofol. After intubation remifentanil was infused at a constant rate of 0.2 μg/kg/min whereas sevoflurane in 1.5/min O2/air was adjusted according to EEG target values or clinical parameters: during maintenance of anaesthesia to a value of 60” (Narcotrend) or 50” (BIS), 15 min before the end of surgery to “70” (Narcotrend) or “60” (BIS), whereas in the standard protocol group sevoflurane was controlled according to clinical parameters, e.g. heart rate, blood pressure, movements. Recovery times and sevoflurane consumption were recorded by a blinded investigator. The sevoflurane vaporiser was weighed before and after anaesthesia and mean remifentanil dosages.

Results: The groups were comparable for demographic data, duration of anaesthesia and mean remifentanil dosages.

A-121

Changes of EEG in pediatric patients with cerebral palsy during sevoflurane-fentanyl anesthesia

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Background and Goal of Study: We previously investigated the changes of EEG in pediatric patients who had no neurological disorder during sevoflurane-fentanyl anesthesia. Here we investigated the changes of EEG in pediatric patients who had cerebral palsy.

Materials and Methods: After institutional approval and obtained informed consent, we enrolled 22 patients with cerebral palsy (7.1 ± 3.3 years, M/F = 17/5) who received tendon elongation or transfer of lower limbs. Patients who had epilepsy or mediated psychotropic drugs were excluded from this study. 1 mg/kg of diazepam was premedicated orally 30 minutes before admission to the operating room. Anesthesia was induced with inhalation of sevoflurane 5%. After confirmed of venous line, 3 μg/kg of fentanyl and 0.1 mg of vecuronium were administered. Then the trachea was intubated. Using the software we developed, we continuously recorded FP–A1 lead of the EEG signal and expired sevoflurane concentration to an IBM-PC compatible computer. After confirming the steady state of each sevoflurane (end-tidal concentration at 0.5%, 1.0%, 1.5% and 2.0%), SEF90 and mean amplitude of EEG were calculated. During surgery 2 μg/kg of fentanyl was added in requirement. We gathered EEG data at sevoflurane 2.0% and 1.5% during surgery, and at sevoflurane 1.0% and 0.5% after finished the operation.

Results and Discussions:

<table>
<thead>
<tr>
<th>Sevo</th>
<th>0.5%</th>
<th>1.0%</th>
<th>1.5%</th>
<th>2.0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amp(μV)</td>
<td>9.1 ± 1.8</td>
<td>22.6 ± 5.4</td>
<td>38.0 ± 8.8</td>
<td>43.0 ± 9.0</td>
</tr>
<tr>
<td>SEF90</td>
<td>17.4 ± 3.6</td>
<td>19.7 ± 1.8</td>
<td>14.3 ± 1.8</td>
<td>12.1 ± 1.0</td>
</tr>
</tbody>
</table>

(↑p < 0.05 vs. prev. value)
Both EEG amplitude and SEF90 showed similar changing pattern which we observed in pediatric patients without neurological disorder.

**Conclusion(s):** EEG monitoring would be valuable in pediatric patients with cerebral palsy.

**Reference:**

A-122

**Attitudes of anaesthetists to awareness and depth of anaesthesia monitoring**

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**Background and Goal of Study:** Depth of anaesthesia monitoring has been the subject of persistent study and scepticism, often polarising the views of the profession. A Swedish study showed an incidence of awareness under anaesthesia of 0.18% to 0.1%. We performed a survey of consultant anaesthetists in the U.K. to ascertain their attitudes to awareness and depth of anaesthesia monitoring.

**Materials and Methods:** Following Research Ethics Committee approval, questionnaires, based on an Australian survey, were sent to anaesthetic consultants in the U.K. The responses were anonymised.

**Results and Discussions:** Of the 4927 questionnaires sent out, there was an overall response rate of 44%. Fifty-nine percent of respondents perceived awareness to be a minor problem. Seventy percent thought the national incidence was 0.02% or more. One third have had patients with awareness. Only 4% routinely warn their patients of the risk of awareness during pre-operative visits. Although 20% believe that anaesthetists should routinely ask about recall during a post-operative visit, only 7% actually do so. In 91% of the responses, the tidal anaesthetic gas concentration was thought to reduce the likelihood of awareness. Clinical signs were considered unreliable indicators of awareness by 80% of respondents. Only 41% would “always” or “usually” use depth of anaesthesia monitoring if it was available.

**Conclusion(s):** The perception of the national incidence of awareness is in keeping with other literature. Awareness is perceived as a ‘minor’ problem and the reasons need to be investigated. Many still believe end tidal volatile agent monitoring is useful in reducing the risk of awareness. Respondents remain unconvinced about the efficacy of currently available depth of anaesthesia monitors in preventing awareness.

**References:**

**Acknowledgements:** All expenses were met by the Cambridge University Department of Anaesthesia.

A-123

**Cerebral state index (CSI): time delay of index calculation**

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**Background and Goal of Study:** The cerebral state index (CSI) has recently been introduced as a measure of the hypnotic component of anaesthesia. Based on spontaneous EEG processing, it is calculated by the cerebral state monitor (CSM). The CSI is displayed as a dimensionless number between 0 and 100 and inversely correlates with depth of hypnosis. All currently available monitors require some unknown time to calculate an index value. The aim of this study was to determine the duration of this time delay for the CSI.

**Materials and Methods:** Artificially generated EEG signals were used to produce three different CSI values: “awake” (CSI 89), “general anaesthesia” (CSI 42) and “deep anaesthesia” (CSI 0). All signals produced constant CSI values. The time interval also depended on the baseline index value. Respondents remain unconvinced about the efficacy of currently available depth of anaesthesia monitors in preventing awareness.

**Results and Discussions:** For increasing values, time delays were between 15 and 155 sec, for decreasing values from 53 to 55 sec. We revealed two details: First, at the signal change from CSI 0 to CSI 42 the CSI value reaches and maintains a plateau at CSI 33, then rises again until a constant CSI of 42 is reached. Second, we revealed the novelty of an overshoot reaction at the transition from “general anaesthesia” to “awake”: the CSI initially increases from 42 to 95, then subsequently decreases to 89, the appropriate index value for the underlying signal. This overshoot additionally exists at the transition from CSI 89 to 42 and from CSI 89 to 0.

**Conclusion(s):** The time interval before a new index value was obtained was not constant. Calculation times were different for decreasing and increasing CSI values. The time interval also depended on the baseline index value. This is important if the CSI is used as a tool for pharmacodynamic studies. The overshoot reaction at the transition from “general anaesthesia” to “awake” can be seen as an additional warning of patient’s awareness. The fastest response was calculated at transition from CSI 42 to 89, indicating good results for detection of awareness.

**Reference:**

A-124

**Detection of different levels of anaesthesia by auditory evoked potentials: from loss of consciousness to burst suppression**

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**Background and Goal of Study:** Auditory evoked potentials (AEP) have been suggested as a measure of the hypnotic component of anaesthesia (1). The present study was designed to compare parameters obtained by automated AEP analysis with results of visual analysis (2) in respect to their ability to characterise different levels of anaesthesia.

**Materials and Methods:** 15 unpremedicated consenting volunteers were enrolled into HiC-approved study. On two different days, they received propofol via target controlled infusion or sevoflurane mono-anaesthesia. Standard monitoring parameters, EEG and AEP were continuously recorded (electrode positions: A1, M2, Fz (reference) and F7 (ground), binaural rarefaction clicks, 70 dB, 8.3291 Hz, 10% variability of the interstimulus interval). Time of measurements: Volunteers were instructed to relax and close eyes; Anaesthesia was slowly induced until loss of consciousness (LOC). The drug concentration was increased until Burst Suppression (BS) was seen in the EEG. The difference of drug concentrations at LOC and BS was divided into three equal intervals, leading to two intermediate levels (Inter2 and 1). At each level (LOC, BS, Inter2, Inter1), the drug concentration was maintained for 15 min. From the last 3 min of each level, an AEP was analysed (20 volunteers: 10 propofol, 10 sevoflurane). AEP parameters were calculated and ranked by their ability to separate the different levels using PK analysis.

**Results and Discussions:** Automated analysis revealed Pk values > 0.85 for: (1) root mean square of the 1st signal derivative (0.86), (2) variance of 1st signal derivative (0.86), (3) mean absolute amplitude of 1st signal derivative (0.85), in the visual analysis Pk values of amplitudes (Na: 0.73, Pa: 0.74, Nb: 0.78, Pb: 0.70, N1: 0.70) and latency (Na: 0.62, Pa: 0.60, Nb: 0.55, Pb: 0.53, N1: 0.53) were found.

**Conclusion:** LOC and BS are defined endpoints of the full range of anaesthesia. The different levels of anaesthesia were defined by individual effects of the given drug. Three parameters of the automated analysis were identified that can be used to distinguish between different levels of this range. Visual analysis was less useful to distinguish between the different levels.

**References:**

A-125

**Time delay of EEG index calculation: analysis of Narcotrend® and bispectral index**

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**Background and Goal of Study:** Monitoring of anesthetic depth with EEG derived parameters during surgery may detect awareness reactions and thereby may help to decrease the incidence of intraoperative awareness. All currently available indices need some time to react to a change in the state of consciousness. The exact amount of time is unknown. The aim of this study was to determine the latency of two frequently used indices – the bispectral index (BIS) and the Narcotrend® index.

**Materials and Methods:** Artificial EEG signals were used to generate constant BIS and Narcotrend® index values. These values indicated “awake” (general anaesthesia) and “deep anaesthesia” (total suppression of cortical activity). After a switch from one simulated state of consciousness to another, the time necessary for both indices to adjust the displayed index was recorded.

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Results and Discussions: We found that both indices showed latencies between 14 and 145 s before the new state was indicated. In general, BIS adapted faster (14–66 s) than Narcotrend® (45–145 s).

<table>
<thead>
<tr>
<th>Change in input signal</th>
<th>Time to new index (s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>From</td>
<td>To</td>
</tr>
<tr>
<td>Deep anes</td>
<td>General anes</td>
</tr>
<tr>
<td>General anes</td>
<td>Awake</td>
</tr>
<tr>
<td>Awake</td>
<td>General anes</td>
</tr>
<tr>
<td>General anes</td>
<td>Deep anes</td>
</tr>
<tr>
<td>Deep anes</td>
<td>Awake</td>
</tr>
<tr>
<td>Awake</td>
<td>Deep anes</td>
</tr>
</tbody>
</table>

n.a.: not applicable

Latencies of the tested indices limit their value in prevention of recall of intraoperative events. Interestingly, latencies for display of new index values were different between ascending and descending values.

Conclusion(s): This indicates a limitation for the use of both monitors for pharmaco kinetic and -dynamics studies.

A-126
High frequency components of auditory evoked potentials are detected in responsive, but not in unconscious patients
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Background and Goal of Study: The dose dependent suppression of mid-laryngeal auditory evoked potentials by general anaesthetics has been proposed to measure depth of anesthesia.1 In peroperatively recorded mid-latency auditory evoked potentials were analysed in a time-frequency space to identify significant changes induced by general anesthesia.

Materials and Methods: Perioperatively recorded AEPs (binaural stimuli, 1000 sweeps) of 19 patients were submitted to a multi scale wavelet analysis. We calculated energy contents of the signal in several frequency bands.

Results and Discussions: Statistical evaluation showed a highly significant decrease of the wavelet energies for the frequency bands 57.1–114.3 Hz, 114.3–228.6 Hz and 228.6–457.1 Hz.

Results and Discussions: Statistical evaluation showed a highly significant decrease of the wavelet energies for the frequency bands 57.1–114.3 Hz (p = 1.49 × 10^-9) and 114.3–228.6 Hz (p = 1.35 × 10^-9) for the measuring points representing deep general anesthesia, accompanied by a significant decrease of the wavelet energy of the frequency band 228.6–457.1 Hz (p = 0.0006) and a decrease in the wavelet energy of the frequency band 0–57.1 Hz of no statistical significance (p = 0.03), most prominent in the post stimulus interval between 10 ms and 30 ms.

Conclusion(s): These high frequency components may therefore not only reflect the response of the target organ of anesthesia, but a surrogate parameter, i.e. muscle activity.

References:
1 Drummond JC: Monitoring depth of anesthesia: with emphasis on the application of the bispectral index and the middle latency auditory evoked response to the prevention of recall. Anesthesiology 2000; 93:876-882.

A-127
Clinical tests are worthless in predicting objective neuromuscular recovery
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Background and goal: To assess if clinical tests are good predictors of objective neuromuscular recovery as registered by the train-of-four (TOF) ratio.

Materials and methods: In 630 patients, the TOF ratio was measured and 8 clinical tests were performed at arrival in the recovery room. The patients had all received a single bolus of neuromuscular blocking drug (NMBD) at induction. The choice and dosage of NMBD had been at the anaesthetist’s discretion. The clinical tests were: ability to smile (A), ability to swallow (B), ability to speak (C), appearance of general weakness (D), sustained head lift for 5 s (E), leg lift (F), hand grip (G) and sustained tongue depressor test (H).

Results: Table 1 shows the relation between the TOF and the number of positively scored clinical tests. Table 2 shows the best combination of tests for each positive score between 1 and 8 (Pearson and Spearman correlations).

Table 1. Sum of tests vs. TOF category.

<table>
<thead>
<tr>
<th>Sum of +ve tests (% patients)</th>
<th>TOF &lt; 70% (% patients)</th>
<th>70% &lt; TOF &lt; 90% (% patients)</th>
<th>TOF &gt; 90% (% patients)</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>12</td>
<td>21</td>
<td>67</td>
</tr>
<tr>
<td>0</td>
<td>27</td>
<td>15</td>
<td>58</td>
</tr>
</tbody>
</table>

Of the patients with a good score in all the clinical tests, 12% still belonged to the category of ‘clinically dangerous’, while among those with a bad score, 58% had an ‘ideal’ TOF ratio (Table 1). The correlations were low (Table 2), so none of the combinations of clinical tests were good predictors.

Conclusion: The clinical tests considered here are not good predictors of objective neuromuscular recovery as measured by the TOF ratio.

A-128
Clinical evaluation of the TOF-tube
P.E. Dubois
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Background and Goal of Study: The risk of postoperative residual curarisation can be eliminated by the correct use of acceleromyography (AMG).1 Furthermore, its peroperative use insures adequate surgical relaxation. The only requirement is that the thumb must be allowed free movement. This is frequently impossible during surgical procedures.

We investigated the clinical feasibility of AMG protected inside a new device: the TOF-tube (2).

Materials and Methods: The rigid and tubular TOF-tube allows safe positioning of the hand while ensuring thumb mobility under the surgical sheets (Fig. 1).

Results and Discussions: The patients (n = 64) underwent various types of surgery (including gynaecological, abdominal, cardiac, ENT, orthopaedic) in supine position (95%) with the arm alongside the body (78%) or on an armboard.

1 Drummond JC: Monitoring depth of anesthesia: with emphasis on the application of the bispectral index and the middle latency auditory evoked response to the prevention of recall. Anesthesiology 2000; 93:876-882.

Conclusions: In daily practice, TOF-tube improves the functioning of AMG in various types of surgery and installations. Further improvements of the device will occur taking comments into account.

References:

A-129
Acceleromyography reproducibility using the TOF-tube: a comparison with mechanomyography and electromyography
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Background and Goal of Study: Acceleromyography (AMG) is used in clinical practice to monitor neuromuscular blockade. However, problems remain in obtaining stable values, making the interpretation of results difficult (1). Furthermore, the thumb must move freely which is frequently impossible under the sheets during the surgical procedure.

This study compares train-of-four ratios (TOFr) recorded at the end of surgery with mechanomyography (MMG), electromyography (EMG) and AMG protected inside the TOF-tube, a rigid tubular device allowing safe positioning of the hand while ensuring thumb mobility under the surgical sheets (2).

Materials and Methods: After Ethical Committee approval, neuromuscular blockade was investigated in 20 informed patients under general anaesthesia. Two consecutive TOFr (15 s interval) were obtained on both hands simultaneously using one on side MMG and EMG, and on the other AMG installed inside the TOF-tube. The evaluation of repeatability between each paired TOFr was performed by assessing the bias, the precision, and the limits of agreement using the Bland and Altman method.

Results: Expressed in % as mean ± SD. Mean TOFr was 75 ± 15 at the end of surgery.

<table>
<thead>
<tr>
<th></th>
<th>MMG</th>
<th>EMG</th>
<th>AMG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bias</td>
<td>-0.30 ± 1.80</td>
<td>-0.04 ± 2.94</td>
<td>-0.75 ± 2.65</td>
</tr>
<tr>
<td>Precision</td>
<td>1.10 ± 1.45</td>
<td>1.76 ± 2.35</td>
<td>1.85 ± 2.01</td>
</tr>
<tr>
<td>Limits of agreement</td>
<td>-3.82/3.22</td>
<td>-5.80/5.73</td>
<td>-5.95/4.45</td>
</tr>
</tbody>
</table>

Conclusion: Inside the TOF-tube, its protective device, AMG shows an inter-measureability variance of the same magnitude as EMG. This allows a better interpretation of AMG results during the surgical procedure.

References:

A-130
Transcutaneous electrical stimulation of the P-6 acupuncture point with a nerve stimulator that monitors neuromuscular function, reduces PONV
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Background and Goals: Acupuncture at P6-point (volar anterior ante-brachial region) during gynecologic surgery reduces the incidence of postoperative nausea and vomiting (PONV) (1). Transcutaneous electrical stimulation of P6-point reduced nausea, but not vomiting after cholecystectomy (2). In this RCT we used a conventional neuromuscular stimulator to measure neuromuscular blockade for the stimulation of the ulnar nerve or the median nerve at the P6-point to determine the incidence of PONV.

Materials and Methods: We planned to evaluate 220 ASA I–III women undergoing elective laparoscopic surgery under standardized anesthesia upon the incidence of PONV during the first 24 hours. Besides demographic data and standard anesthesia safety monitoring, severity of nausea and vomiting, pain-score, rescue anti-emetic medication were recorded for the early (first 6-h) and late (6–24-h) postoperative period.

In half of the patients neuromuscular blockade was monitored with a nerve stimulator (TOF-watch3, Organon, NJ) above the ulnar nerve at the wrist in single twitch mode (1-Hz). The aim of neuromuscular blockade during surgery was 10% of the twitch height of the baseline reading. The intervention group was stimulated as described above at the P6-point above the median nerve.

Results and Discussions: From 60 patients studied (out of 220 planned).

Demographic data, intra- and postoperative hemodynamic measurements and medication, pain score and rescue medication was comparable between the 2 groups and the 2 time periods. The overall PONV incidence was 40% over 24-h and 32% in the first 6-h. Stimulation of the P6 point reduced PONV significantly (15% vs. 54%; P < 0.05) and nausea (11% vs. 46%; P < 0.05) but not vomiting in the 1st 6-h after surgery. No difference was found for the late postoperative period.

Conclusion(s): Continuous intraoperative transcutaneous stimulation of the P6 acupuncture point at the volar side of the wrist with a conventional nerve stimulator for the monitoring of neuromuscular blockade in the single twitch mode reduces PONV and nausea in the 1st 6-h after surgery.

References:

A-131
Neuromuscular blockade monitoring in obese patients
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Background and Goal of Study: We have found more differences between the degree of neuromuscular blockade (NMB) measured with peripheral nerve stimulator (PNS) and that evaluated by the surgeons in obese patients (OP) compared with normal weight patients (NWP). This can be secondary to insufficient electrical stimulation. Our goal is to determine the surface supramaximal stimulation (SS) on ulnar nerve in OP and compare it with that of NWP.

Materials and Methods: After Ethical Committee approval and written consent, 10 OP (BMI > 35 kg/m²) and 10 NWP (BMI 20–25 kg/m²), ASA I–II, scheduled for elective surgery under general anesthesia, were studied prospectively. Measurements were made after i.v. induction with fentanyl 1–3 µg/kg and thioental 2–5 mg/kg. A Datex® monitor MNT221 was used to determine automatically SS. The monitor has a maximal intensity output of 70 mA. Patients who did not achieve a maximal response with 70 mA were recorded as SS > 70. Demographic data, wrist circumference (cm) and SS measured (mA) were registered. Statistics were with Student’s t-test, Fisher’s exact test and lineal correlation. A p < 0.05 was considered statistically significant.

Results and Discussions: There were no differences in sex, age and height between groups. Weight was 114 ± 19 vs. 65 ± 11 kg (p < 0.001), BMI 40 ± 5 vs. 23 ± 2 kg/m² (p < 0.001) and wrist circumference 19 ± 3 vs. 16 ± 2 cm (p < 0.001) in OP and NWP, respectively. Six out of 10 OP had a non-determinable value >70 mA, while all the NWP had SS ≤ 70 mA (p = 0.011). A mild positive correlation between wrist circumference and SS (r = 0.476; p < 0.05) was found. All patients with a wrist circumference <18 cm (n = 9) had SS ≤ 70 mA.

Conclusion(s): Monitoring of NMB with SS < 70 mA is not reliable in OP. Since most neuromuscular stimulators have a maximum output of 70 mA, this can be the cause of discrepancies between the clinical impression and that measured by PNS. In patients with a wrist circumference <18 cm, the use of a <70 mA stimulation is possibly adequate.

A-132
Complex Myograph: evaluation of a diagnostic device and standard values for force, velocity and working capacity of the muscle in-vivo
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Background and Goal of Study: With the newly developed Complex Myograph it is possible for the first time to determine the individual muscular contraction force, velocity, and work at the point of optimum muscle pre-stretching. This trial investigates the reproducibility and the precision of the measuring method. Physiological standard values for force, velocity and work are presented.

Materials and Methods: The experiments in this study are in-vivo conducted on muscles adductor pollicis. A self-developed device brings the physiological rotation axis in a congruent position with the axle of the apparatus, holds it there, and brings the muscle on the optimum of pre-stretching.
Colonic segments (length 8 cm) were fixed on a polyacrylic tray filled with

**Materials and Methods:** Target-controlled propofol and sufentanil infusions were administered to 12 morbidly obese patients (body mass index: 42.5 [41.8–44.5] kg/m²). The target plasma propofol concentration was 3 to 4 μg/ml whereas the sufentanil infusion rate was 0.2 to 0.4 μg/kg/h adjusted on blood pressure and heart rate. A bolus dose of atracurium (0.5 mg/kg) was given intravenously after onset of unconsciousness to facilitate tracheal intubation. Additional atracurium bolus (0.2 mg/kg) was given when inadequate surgical field was observed by the surgeon (JMC) who was blinded for the depth of neuromuscular blockade. The depth of neuromuscular blockade was monitored by using peripheral nerve stimulator. The evoked response to the train-of-four (TOF) stimulation was measured by acceleromyography at the adductor pollicis (AP) and the corrugator supercilii (CS). A post tetanic count (PTC) was measured at the AP when the recovery of the first response to CS TOF was done. Results were given as median [interquartile 25–75].

**Results and Discussions:** The characteristics of the patients were age 43 [31–48] yrs; women 75%; ASA 2 [1–2]. The surgical procedure lasted 125 [99–139] min. After 0.5 mg/kg atracurium, time to obtain 0 response to TOF at the CS was 135 [120–132] seconds. Twenty two atracurium bolus were given according to the surgical demands: 0 in two patients, 1 in three patients and >2 in seven patients. Seventeen (77%) demands occurred whereas less than 2 responses to TOF at AP were observed. No demand occurred before the recovery of 2 responses to TOF at the CS. The recovery of the 1 response to TOF at CS corresponded to 2 (1–3) responses to PTC at AP.

**Conclusion(s):** Based on the surgical demand, the majority of the patients needed atracurium bolus during laparoscopic gastroplasty. The TOF at AP did not allow to anticipate the surgical demand. The TOF at the CS and/or the PTC at the AP were more adapted to the surgical demand.

**A-135**

Titration of desflurane using BIS when the anaesthesia is supplemented by intravenous administration of remifentanil or by epidural blockade during urological procedures

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**Background and Goal of Study:** The purpose of this study was to compare the effect between remifentanil infusion and epidural analgesia on desflurane requirements using bispectral index (BIS) in patients who underwent urological procedures (prostatectomies, cystectomies).

**Materials and Methods:** Thirty patients ASA I–III, aged 60–85 were randomly assigned to the remifentanil group (group A) which received continuously i.v. remifentanil (0.15–0.25 μg/kg/min) or the epidural group (group B) which received epidurally (O1–O2) a local anaesthetic ropivacaine 0.75% followed by boluses if needed throughout the operation. Anaesthesia was maintained with desflurane with fresh gas flow 2 L/min (80% N2O in O2). The end tidal concentration of desflurane was titrated so that BIS values to range between 45–60. The median end tidal desflurane was calculated in each patient when BIS was in the desired range every 5 minutes. For statistical analysis was used the paired sampled t-test. A threshold p value of 0.05 was set to determine the statistically significant differences.

**The two groups were comparable with respect to demographic characteristics, haemodynamic variables and BIS values throughout the study.**

**Results and Discussion:** The required end tidal concentration of desflurane in the remifentanil group was significantly lower p < 0.05 compared with the epidural analgesia group (1.8 (0.3) vs 2.43 (0.82) respectively).

**Conclusion:** In conclusion the end tidal concentration of desflurane required to maintain BIS values 45–60 is higher when analgesia is maintained with epidural block versus analgesia obtained with i.v. infusion of remifentanil in patients who underwent urological procedures.

**References:**

**A-136**

Mobile phone usage within hospitals – the reality

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**Background and Goal of Study:** Mobile phones and wireless technology have become a major part of modern life. It is estimated that 85% of UK households own a mobile phone. The Medicines and Healthcare products
Regulatory Authority (MHRA) produced new recommendations about mobile communication systems in August 2004. Many UK hospitals ban all use of mobile phones within hospital buildings. Despite this, many people in hospitals continue to use mobile phones, yet the authors could find no data supporting this observation. This study assesses the current level of mobile phone usage within two city teaching hospitals.

Materials and Methods: A simple, anonymous, ‘yes/no’ questionnaire was used. 444 questionnaires were distributed to and completed by staff in two city teaching hospitals over a 48 hour period. Completed forms were divided into three staff categories: group 1 – nursing, group 2 – medical, group 3 – others – cardiology technicians, domestic staff, medical physicists, pharmacists, etc.

Results and Discussions: 60% of questionnaires were completed by nursing staff, 18% by medical staff and 22% by others. 94% (n = 417) owned a mobile phone, of which 90% (n = 376) regularly brought their mobile phone to work. Of those who brought their mobile phone to work, 46% (n = 174) admitted to having mobile phone switched on in a clinical area. This equates to 39% of all staff having a mobile phone switched on in a clinical area. Whilst there is undoubtedly a degree of bias in this data, there appears to be a significant proportion of staff ignoring hospital policy. The authors suggest that these results represent an under-reporting of mobile phone usage within clinical areas.

Conclusion(s): Despite current hospital policy prohibiting use of mobile phones, this data suggests that more than a third of all hospital staff disregard this policy. These results support the MHRA that it is impossible to enforce a mobile phone ban effectively, and endorse the MHRA recommendation that healthcare providers should actively manage wireless technology.

References:

A-137
Implementation of an ICU Data Management System by using the standard Hospital Information System SAP R/3
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Background and Goal of Study: Information technology (IT) may help to support organisational and medical ICU processes. However, available PDMS’s are expensive, and there full integration into the standard Hospital Information System may be difficult. Our aim was to create an in-house developed cost-effective IT system based on SAP R/3 (Walldorf, Germany).

Materials and Methods: Programming was focussed on clear and consistent documentation, concentration on critical data sets necessary for medical decisions, support of medical and organisational processes and generation of patients’ records and outcome data. Various documents were generated to obtain structured information from the operating theatre, preoperative clinic, emergency room and concomitant specialties in order to assist risk management and to individualise ICU treatment (Fig 1).

Results and Discussions: Development of this system by one computer engineer and two ICU-doctors took one year. After a test period of two weeks its application was fully implemented. In the first four months more than 600 patients were managed by using this system. As the same interface as with SAP was used the system was widely accepted by the entire ICU staff.

Conclusion(s): An in-house developed ICU-data-system based on SAP R/3 may be an adequate and cost-effective tool for ICU data management.

A-138
Improving departmental administration using a dynamic database-driven website
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Department of Anaesthesia, St George Hospital, Sydney, Australia

Background: Internet use has grown exponentially in the 12 years since public access became available. In a 2001 survey of Australian Anaesthetists, 87% had internet access at home or work. (1) Many medical practitioners see web sites as simple advertisements for a hospital. By providing a dynamic user specific “portal” to an entire department’s activities and resources, considerable gains in workplace efficiency, safety and morale may be made.

Materials and Methods: St. George Hospital in Sydney, Australia has developed a departmental website, which has become an essential clinical and administrative tool. Some of its functions include: call rosters with the facility to make immediate changes; lists of departmental meetings; a messaging system; an email system; daily operating room allocations of surgical and anaesthetic teams; staff leave calendar; staff directory of contact numbers, pagers, mobiles and email addresses; publications and resources.

Results: A recent survey (December 2004) of all users (n = 60, 33 residents) found 91% considered the website had improved the way they worked, 94% believed it saved them time, 76% believed that online patient alerts allowed them to be better prepared for complex patient presentations and 41% believed it reduced the chance of workplace errors. Local users log into the website on average every two days.

Discussion: A successful website requires content that is:
Dynamic: the content of the web site is generated every time it is viewed to reflect the “current” status, e.g. roster changes or meeting cancellations immediately shown.
User specific: what is seen is tailored to the person viewing it, e.g. when logged in the user is told when they are next on call or the subject of the next meeting.
User Editable: content is changed and expanded by users, e.g. users can arrange call exchanges which are immediately updated, and confirmatory emails automatically sent to the staff involved. Users can change their contact details; enter new messages, meetings or publications. Documents can be uploaded and stored using a filing system for easy access.

References:

A-139
Auditory signals in operating rooms soundscape
L. Bourgeon, J.-B. Cazalaï, C. Valot, A. Guillaume
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Background and Goal of Study: Warning signals in operating rooms are often denounced by anaesthetists as too numerous and then as a nuisance (1). The goal of the study is to observe the part of the auditory signals of anaesthetic equipments in the operating room soundscape.

Materials and Methods: Observations have been realised in three hospitals (A, B, C) during sixteen surgical operations (5 in A, 5 in B and 3 in C). We used a video camera to record occurrences and timings of the auditory signals. An observer noted nature of signals distinguishing anaesthetic equipments (An. eq.) from non-anaesthetic equipments (N-an. eq.).

Results and Discussion: Mean auditory signal occurrences per hour (±SD) are shown as a function of signal category and hospital in the Table:

<table>
<thead>
<tr>
<th>Hospital</th>
<th>A</th>
<th>B</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auditory Signals:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>An. eq.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>W</td>
<td>20.5 ± 10.2</td>
<td>0.8 ± 0.4</td>
<td>0.8 ± 0.4</td>
</tr>
<tr>
<td>EK</td>
<td>4.1 ± 5.7</td>
<td>0.4 ± 0.8</td>
<td>0.4 ± 0.8</td>
</tr>
<tr>
<td>Warning</td>
<td>9.5 ± 2.5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Equip.</td>
<td>34.2 ± 4.6</td>
<td>21.4 ± 8.3</td>
<td>28.2 ± 11.9</td>
</tr>
<tr>
<td>Key</td>
<td>9.4 ± 9.4</td>
<td>4.5 ± 7.8</td>
<td>8.6 ± 9.7</td>
</tr>
<tr>
<td>Recorded</td>
<td>4.6 ± 4.7</td>
<td>4.5 ± 3.7</td>
<td>7.4 ± 2.3</td>
</tr>
<tr>
<td>Data</td>
<td>13.9 ± 10.3</td>
<td>4.5 ± 6.5</td>
<td>16 ± 7.4</td>
</tr>
<tr>
<td>Surgical</td>
<td>48.1 ± 9.2</td>
<td>30 ± 13.7</td>
<td>44.3 ± 19.1</td>
</tr>
</tbody>
</table>

Downloaded from https://www.cambridge.org/core, IP address: 35.160.27.221, on 21 Apr 2022 at 00:03:23, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/S0265021505001341
For the three hospitals, N-an eq signals represented more than the third of all the auditory signals with a large part from surgical signals that cannot be reduced. Concerning the An-eq signals, soundscapes were different among the three hospitals (p < 0.001). We observed less warning signals in Hospital A than in the others but the total of An-eq signals was greater than in the other hospitals. This is due to the working of its recent anaesthetic equipment that was designed to decrease warning signals but leads paradoxically to a high increase of the auditory signals in the operating room with recording data signals (EK, RD).

**Conclusion:** N-an eq signals represent a large part of the soundscape in the operating room. Then, An-eq designers must be careful not to increase the number of auditory signals when trying to decrease warning signals.

**Acknowledgement:** This work was supported by DCSSA.

**References:**

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**A-140**

**Introduction of an Operating Room (OR) Scheduling and Management Information System increased overall performance**

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**Introduction:** Operating room information systems should guide the allocation of the optimal amount of block time for every surgeon. This should minimize the sum of costs of unused block time as it should minimize the costs of elective cases being performed outside normal block times. In the present paper, we want to illustrate how the introduction of a visual display of real-time OR activity, as part of an Operating Room Scheduling and Management System, influenced our daily OR activity performance in view of unused or excess OR time.

**Materials and Methods:** Since January 2001, we introduced an OR status screen, chronologically displaying all scheduled OR activity pro OR suite. This screen is linked in real-time activity with all OR suites, where predefined taskgroups and events (start and end of procedure) are automatically triggered by network technology. For the aim of this paper, we compared all data of OR activity performance for abdominal surgery for the first half of 2000 to the first half of 2001, using the Mann–Whitney U-test.

**Results:** From January to June 2000, 764 elective cases were performed, whereas 815 cases were performed during the first half of 2001. For both periods, the total OR time allocated to abdominal surgery for this 6 months period was 805 hrs. For 2000, the total duration of OR activity performed for elective abdominal surgery was 1044 h 50 min (resulting in 239 h 50 min total over-time), whereas for 2001 a total of 1127 h 35 min (resulting in 322 h 35 min total over-time) was registered. For 2000, we recorded 147 h 20 min of excess time (exceeding the time limits of normal OR activity and inducing extra costs) and 46 h 45 min of unused OR time (within the total OR time allocated to elective abdominal surgery). For 2001, we recorded 123 h 04 min of excess time and 35 h 21 min of unused time.

**Conclusions:** In 2001, we recorded an increase in total OR activity for elective abdominal surgery by 7% in number of procedures (815 vs 764) and by 8% in total duration (1127 h 35 min vs 1044 h 50 min). However, this increase did not result in an increase in excess time or in extra costs, mainly by a significant reduction in unused time or by an increased performance.

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**A-141**

**Leg bio-impedance measurement is good for foot pumps evaluation**

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**Background and Goal of Study:** There was no simple and easy method for comparing anti-DVT (deep vein thrombosis) foot pumps performance. An Ultrasonic Doppler flow meter needs much time and effort for multi-time measurements. We made a simple and easy comparing method using bio-impedance measurement.

**Materials and Methods:** We studied six types foot pumps in each 15 male healthy volunteers (aged 32.1 ± 8.7 years old, mean ± SD). After electrical fixation on dorsal foot and frontal thigh, we measured bio-impedance with computer controlled LCR meter under 20kHz 20mA transmit current. Compression pressure was monitored with ventilator performance analyzer. Studied foot pumps are A-V Impulse System old/new type (Novamedix), Venostream (Terumo), DVT-2500 (Medomer), Venaflow (Aircast), Wizair DVT (MCS).

**Results and Discussions:** Control leg impedance was 849.2 ± 94.2. Impedance changes are clear (Figure 1) and parallel with compression pressure waves. Impedance changes in Venostream, A-V Impulse old type, DVT-2500 were significantly higher than Wizair DVT and A-V Impulse new type. Bio-impedance changes response to both intra cellular fluid and extra cellular fluid. But changes in the short period were supposed to show blood volume changes (1.2). Therefore impedance change is a good blood volume shift parameter.

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**A-142**

**Implementation of an Anesthesia Information Management System (AIMS)**

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**Background and Goal of Study:** We have recently implemented AIMS in our operating rooms. Although the accuracy of automated charts over handwritten ones is well established, the burden of implementation, other than direct costs, is not clear. We report our experience in the process.

**Materials and Methods:** The system implemented is an open system requiring customization, a project manager and four super-users from within the anesthesia staff were trained by the vendor. This group provided training for the rest of the department, customization, and maintenance. User satisfaction was evaluated at implementation and after 4 months. Data entry into the chart and the occurrence of artifacts was evaluated after 4 months.

**Results and Discussions:** The anesthesia department has a staff of 36 physicians (16 residents), with a median age of 41 (35/50) years (1/3 quartiles). Ten have >20 years experience, while 9 have <5. 13 did not previously use computers daily. For the 6-week implementation the project manager worked on the system 100% of the time and the super-users for 50%. Each user had a training session of 90 min. and 6 required a repeated sessions. Maintenance requires 30% of a full time post. For the first 3207 cases ASA score was entered in 98% of the files, the anesthesiologists name in 92% and the type of surgery in 87%. In 65 (~2%) of the cases (excluding cardiac) there were important artifacts (more than 3 readings of either HR >190 or O2Sat <80%). The opinion of the staff about the effect of AIMS anesthesia practice (workload and the attention given to the patient) prior to implementation and after 4 months use is presented in the Table.
Conclusion(s): Even in a clinical department with a high rate of computer illiteracy the implementation of AIMS can be successful, although dedication from leaders is required. During implementation there is significant manpower requirement.

A-143
Comparison of two techniques for intraabdominal pressure monitoring
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Background and Goal of Study: Reliable measurements of the intraabdominal pressure are the basis for treatment of intraabdominal hypertension [1]. The intraabdominal pressure (IAP) usually is assessed via the intra-bladder pressure (IBP). The aim of our study was to validate a continuous technique to measure the intraabdominal pressure via a balloon tipped gastric tube (GT, Spiegelberg) connected to an IAP Monitor.

We compared it with the current standard technique of measuring the intraabdominal pressure (IBP).

Materials and Methods: We measured the intraabdominal pressure in 14 ICU patients after laparotomy (57.6± 19.3 mmHg; APACHE II 17.5 ± 6.3; in total 168 paired measurements were performed). All patients were ventilated (BiPAP) and under sedation. We evaluated the correlation of the GT with the intra-bladder pressure at different bladder-volumes (50 ml to 200 ml), the change of the correlation over time (80 minutes) and than we assessed the reaction to external pressure. All values are shown as mean plus/minus standard deviation (MEAN ± SD).

Results and Discussion: We found a good correlation between both methods with an intra-bladder volume of 50 ml (GT – 1.074 ± 1.082 * IBP; R² = 0.736; p < 0.001). After 60 minutes the correlation was as follows (GT – 1.929 ± 0.908 * IBP; R² = 0.897; p < 0.001). Bland Altman Analyses showed a good agreement (mean bias was 0.2 ± 4.2).

In each patient we measured the reaction to external pressure with both methods. Both systems reacted immediately to the external pressure. The pressure difference in both systems showed a good correlation (GT – 0.905 ± 1.167 * IBP; R² = 0.723; p < 0.001).

Conclusion: The balloon tipped gastric tube may be used for assessing reliable the intraabdominal pressure. The validity of the measurement over a longer period as well as the influence of the body position still has to be evaluated.

Reference:

A-144
Patients’ and healthcare workers’ perception on ambient operating theatre temperatures
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Background and Goal of Study: The study aims to determine the correlation between low ambient operating theatre (OT) temperatures and the incidence of perioperative hypothermia and to understand the perceptions of patients and healthcare workers regarding the ambient OT temperature.

Materials and Methods: 46 patients and 53 healthcare workers (17 surgeons, 19 anaesthetists and 17 nurses) were enrolled. The patient’s body temperature was taken using a tympanic thermometer at 5 points. The questionnaire was completed postoperatively in the recovery room after the patients had recovered from anaesthesia.

Results and Discussions: The mean ambient OT temperature was 18.4 ± 0.2°C. This could explain the high incidence of hypothermia (54.3%) among patients when they left the OT. 95.7% of patients, 94.7% of anaesthesiologists and 94.1% of nurses felt that the OT was cold. However, only 58.8% of surgeons found the OT cold. 84.2% of anaesthesiast and 64.7% of nurses but only 41.2% of surgeons agreed that a higher OT temperature would improve patient comfort and should be implemented. Surgeons find the ambient OT temperature just nice because they wear OT gowns and work under the OT lights. 42.1% of anaesthetists were unwilling to reduce the patient waiting time in the induction room because they require it to prepare the patient adequately. Point of care temperature control may be useful. The patients can be kept warm and comfortable before and after surgery. The OT temperatures can be reduced during surgery once the patient is adequately draped. This will reduce the heat loss from the patients while keeping the surgeons comfortable. Despite feeling cold, 93.5% patients found the cold tolerable. 80.4% did not experience shivering and 84.8% were not uncomfortable. However, 71.7% would rather have a higher OT temperature if they were given a choice.

Conclusion(s): In conclusion, perioperative hypothermia (body temperature <36.0°C) occurs frequently in a cold ambient OT temperature. Majority of patients feel that the OT is cold and that further measures can be taken to improve their comfort. Point of care temperature control may be able to keep patients and healthcare workers comfortable.

A-145
Efficacy of different methods in maintaining normothermia during OPCAB surgery
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Background and Goal of study: Patients become hypothermic during off pump cardiopulmonary bypass surgery (OPCAB) and are exposed to its deleterious effects (1). We evaluated the efficacy in avoiding intraoperative hypothermia of Allon Thermo Wrap™ system: water at a preset desired temperature (T) to a specially designed garment, vs. sterile forced air warming blankets (2).

Materials and Methods: We randomized 32 patients scheduled for elective OPCAB surgery, 3 were excluded after reconverted to CAB [(Group-A)14 pts warmed by Allon, core T objective 36.5°C; (Group-B)15 pts warmed by sterile Bear Hugger™, this blanket was placed on the lower extremities after the saphenous section had been sutured], We collected core T by a nasopharyngeal cathether every 30 min from intubation to the end of surgery. All patients received warmed fluids. The operating room T range was 20–22°C. The Brat 2™ autologous blood recovery system was set up in all cases.

Results and Discussion: There were no statistically significant differences between group’s variables: Age, body surface, ejection fraction, infusions, Hb, and Brat volume recovery. Core T values (Mean ± SD) are shown in the Table.

<table>
<thead>
<tr>
<th>Group-A</th>
<th>Group-B</th>
</tr>
</thead>
<tbody>
<tr>
<td>First T</td>
<td>36.7 ± 0.8</td>
</tr>
<tr>
<td>T End Surgery</td>
<td>36.5 ± 0.2</td>
</tr>
<tr>
<td>T 1 hr ICU</td>
<td>36.7 ± 0.3</td>
</tr>
</tbody>
</table>

Patients of Group-A maintained normothermia because they could be warmed actively before of anesthesia induction and during all procedure. Most of the pts of Group-B were hypothermic at the moment that air blankets, were needed, starting active warming after ICU admission.

Conclusion: Normothermia can be achieved efficiently during OPCAB procedures using the Alion system. It was found to be superior to the air blankets method.

References:

A-147
Prevention of intraoperative hypothermia during laparoscopic surgery of long duration
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Background and Goal of Study: Laparoscopic surgery (L.S.) as a result of CO2 pneumoperitoneum induces intraoperative hypothermia. This is a significant source of morbidity (1), with potential sequelae: cardiovascular (vasoconstriction) and higher incidence of postoperative infection (2). Our aim was to examine the degree of hypothermia and the efficacy of the air warming blankets in preventing it during L.S. of long duration (>2 hours).

Materials and Methods: We randomized 30 patients scheduled for L.S.: hemicolectomy, anterior rectum resection, splenectomy, and Nissen operation. Four patients were excluded (change to laparotomy). [Control group (G-C) 12 pts protected with the usual surgical drapes. Group Bair–Hugger (G-B) 14 pts covered before anesthesia induction with air warming blanket on thorax and the arm exposed], Both groups received perfusions warmed by Hotline™. We collected pharyngeal temperature (core T) and operating room T from induction every 30 min until the end of procedure.
Results and Discussion: There were not statistically differences between variable’s groups: Age, body mass index, volume infusions, surgical time. Evolutions of T are shown in the Table (Mean ± SD).

<table>
<thead>
<tr>
<th></th>
<th>Group-C</th>
<th>Group-B</th>
</tr>
</thead>
<tbody>
<tr>
<td>T Induction</td>
<td>36.1 ± 0.4°C</td>
<td>36.0 ± 0.4°C</td>
</tr>
<tr>
<td>T 60 min*</td>
<td>35.5 ± 0.8°C</td>
<td>36.1 ± 0.4°C</td>
</tr>
<tr>
<td>T End surgery*</td>
<td>35.3 ± 0.7°C</td>
<td>36.4 ± 0.3°C</td>
</tr>
<tr>
<td>T Induction→T End*</td>
<td>(−) 0.8 ± 0.3°C</td>
<td>(+) 0.4 ± 0.9°C</td>
</tr>
<tr>
<td>O.R. final T+</td>
<td>21.1 ± 0.7°C</td>
<td>22.7 ± 1.0°C</td>
</tr>
</tbody>
</table>

* p < 0.05; ** p < 0.001.

The use of air warming blankets kept all the pts of group B normothermic (≥36°C). It is very important to protect the patient before anesthesia induction in order to prevent the initial loss of core T as a result of redistribution of body T.

Conclusions: Laparoscopic surgery induces intraoperative hypothermia as open surgery does. Normotermia can be maintained efficiently using air warming blankets, a safe and not expensive technique. The use of these devices also increases the operating room T at the end of surgery, as a “collateral” protective action.

References:

A-148
Handheld Tesla meter confirmation of gum elastic bougie placement
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Background and Goal of Study: Gum elastic bougie placement (GEB) into trachea has been confirmed by subjective methods. Tesla meter can measure magnetic flux density of magnets. Magnetic flux density of the magnet depends on the distance from the magnet. This pilot study was undertaken to determine whether the measurement of magnetic flux density of magnet attached to the tip of GEB could be used to distinguish endotracheal from esophageal insertion of GEB.

Materials and Methods: Nineteen adult patients (56 ± 19 yr) scheduled for an elective surgery under general anesthesia were included in this study. Routine monitoring and standard anesthesia induction was performed.

Conclusion: Combination of Handheld Tesla meter and GEB with a small magnet was reliable in distinguishing tracheal from esophageal insertion of the GEB.

A-150
A pilot study to detect esophageal intubation using dual channel Visual Stethoscope (VisiStetho)
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Background and Goal of Study: An unobserved esophageal intubation causes significant hypoxemia. To auscultate patient’s breathing and gastric sound using stethoscope is the essential method for confirming the endotracheal tube (ETT) position after tracheal intubation, but it can frequently be inaccurate.

We have tried to invent a new technology for changing the breathing sounds signals into a visual form. We could visualize breathing sounds in a three-dimensional (3-D) color visual form, continuously in the previous study. We improved the Visual Stethoscope (VisiStetho) to visualize two sounds simultaneously. We applied this new dual channel VisiStetho to detect esophageal intubation.

Materials and Methods: Fifty patients who were scheduled to undergo general anaesthesia were involved in this study. Routine monitoring and standard anesthesia induction was performed.

Objective evaluation of the breathing and gastric sound using traditional stethoscope is difficult because it is conducted by a single attending doctor and traditional stethoscope can not evaluate both sounds at once. Using dual channels VisiStetho, it solved these problems.

Conclusion: Dual channel VisiStetho may be an effective tool for detection of accidental esophageal intubation under scheduled general anesthesia.

A-151
A new effective warm-air mattress gives access to the patient
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Background and Goal of Study: To maintain a patient’s core body temperature (CT) during anaesthesia is important (1,2). We evaluated the intraoperative efficacy of a new warm air mattress. It is placed under the patient, thus giving full access to the upper surface of the patient.

Materials and Methods: After ethical approval and informed consent, 12 patients (ASA I-II), scheduled for major abdominal surgery were included. CT was measured rectally (RT) and in the esophagus (ET). Skin temperature (ST) was measured between the skin and the mattress. The warming mattress was started before the induction of general anaesthesia. The aimed CT was ≥36.5°C. The air mattress was disconnected after emergence of anaesthesia and extubation. The RT was recorded 2 and 4 hours postop. The skin was inspected for burns or decubital sores 2 hours postop and the next day. Data are presented as median and range.

Results and Discussion: All patients reached the aimed CT. The initial RT awake was 36.9°C (36–37.3). The lowest RT (36.3, 35.5–36.8) and ET (36.0, 35.5–36.4) were found 79 (20–118) and 79 (15–105) min. after the initiation of the warming. The time to achieve the aimed CT was 68 (0–210) min. for RT and 120 (15–165) min. for ET. The highest ST was 39.6 (37.8–40.5°C). The postop RT were 37.5 (36.0–37.8°C) at 2 hours and 37.9 (35.9–38.6°C) at 4 hours. No signs of burns or decubital sores were found.

Conclusion: Cutaneous warming with this mattress was an effective means of preventing intraoperative hypothermia during prolonged abdominal surgery. No device-related adverse effects were observed. The mattress also gives access to the patient without interrupted warming.

Acknowledgements: This study was supported by KanMed, Bromma, Sweden.

References:
1. IBJ 1997; 79: 796.
A-152
A new infrared temporal-artery thermometer: accuracy and precision during perioperative and ICU/PACU-monitoring
O. Kimberger, C. Sonnleitner, U. Illievich, R. Lenhardt
Department of Anesthesiology and General Intensive Care, Medical University of Vienna, Wien, Austria

Background and Goal of Study: Thermal changes of a patient’s core temperature have significant implications [1,2] and must be monitored closely. Core temperature can be measured at different sites of the body such as bladder, nasopharynx or tympanic membrane, however invasive monitoring is not always possible or wanted. A new temporal-artery (TA) thermometer may be a feasible alternative.

Materials and Methods: We studied 50 patients (25 OR patients, 25 ICU patients); for each patient 7 measurements were performed. The value of the TA-thermometer was recorded twice, averaged and compared with a Mallinckrodt Thermostat built-in-bladder catheter for core temperature measurement. Ambient temperature and forehead-sweating were recorded.

Results and Discussions: The mean difference between TA-measurements and bladder temperature was 0.58 ± 0.46°C. Correlation coefficient for all measurements was 0.721 (p < 0.01).

No influence of sweating was detected on the accuracy of the TA-thermometer.

Conclusion: The TA-thermometer is not yet able to replace invasive core temperature measurement methods due to the low sensitivity for both fever and hypothermia and due to the high mean difference (~0.5°C, above physiological variations [3]) between the TA and the bladder thermometer.

References:
1 Lenhardt R. Anesthesiology 1997; 87(6): 1318-1323.

Clinical and Experimental Circulation

A-153
Effects of pneumoperitoneum on cardiac autonomic nervous activity during laparoscopic surgery
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Background and Goal of Study: The effects of pneumoperitoneum on the activity of the cardiac autonomic nervous system have not been completely understood. Pneumoperitoneum has significant implications for cardiovascular and respiratory status.

Materials and Methods: We studied 16 adult women who underwent laparoscopic cholecistectomy. Patients were anesthetized with 6% desflurane, 2.5-5mg/kg propofol, 1 mg/kg fentanyl. Status of cardiac autonomic nervous system was evaluated by heart rate variability (HRV) three times: once when the patient was awake, once after induction of anesthesia and once after insufflation of pneumoperitoneum. Intradobrinal pressure was maintained automatically at 11mmHg by a carbon dioxide (CO2) insufflator. Patients were divided in two groups: hypertrophic (group A) and nonhypertrophic (group B). All patients underwent transthoracic echocardiography, ECG, ECG Holter 12 hours before surgery, during surgery until 3 hours after surgery; and non-invasive monitoring (blood pressure, heart rate, EtCO2, stroke volume).

Results and Discussions: The groups were similar with respect to demographic data including age, gender and body weight. At baseline HRV was lower in group A than in group B. Mean arterial pressure and HRV decreased at the anesthetized stage and at max insufflations stage. A P < 0.05 was considered significant. No significative differences among two groups in EtCO2, Blood pressure and Stroke volume.

Conclusion: Our dates confirm the reduction of HRV in hypertrophic group and indicates a dramatic decrease of HRV at max pneumoperitoneum stage in this subset of patients.

References:

A-154
Hyperoxia during extreme methemoglobinemia
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Department of Anesthesiology, Intensive Care Medicine and Pain, Johann Wolfgang Goethe-University, Frankfurt am Main, Germany

Background and Goal of Study: Treatment of severe methemoglobinemia (MH) includes the avoidance of methemoglobin-inducing drugs, the application of methylene blue, and the administration of supplementary O2 (1). However, the efficacy of the latter on O2 transport, tissue oxygenation and survival in the treatment of methemoglobinemia is ambiguous (2). We therefore investigated whether hyperoxic ventilation as sole therapeutic intervention (i.e. ventilation with pure oxygen, FIO2 1.0, HV) improves the short-term (6-hrs) survival rate during otherwise lethal methemoglobinemia.

Materials and Methods: In 14 anesthetized pigs mechanically ventilated with room air (FIO2 0.21), the O2 transport capacity was reduced by injection of 15mg/kg 4-dimethylaminophenol (4-DMAP, Köhler Chemie, Germany) inducing the formation of 60 ± 2% methemoglobin. After subsequent randomization ventilation was either continued with room air (G 0.21, n = 7) or with pure O2 (G 1.0, n = 7). A constant level of MH was maintained by continuous infusion of 4-DMAP throughout a 6-hrs follow-up period.

Results and Discussions: Although all animals died within the 6-hrs follow-up period, the survival-time was found prolonged in G 1.0 (G 0.21: 105 ± 30 min; G 1.0: 210 ± 64 min, p < 0.05). No differences were encountered between G 0.21 and G 1.0 regarding the investigated parameters of macrohemodynamics, O2 transport, and tissue oxygenation.

Conclusion(s): In contrast to acute normovolemic anemia HV has negligible effects on oxygen transport and tissue oxygenation during lethal methemoglobinemia (3); nevertheless survival was increased without severe adverse reactions provoked by HV.

References:
3 Meier J. Anesthesiology 2004; 100:70-76.

Acknowledgements: This study was supported by the Else Kröner-Fresenius-Stiftung.

A-155
Heart rate variability may predict heart rate response to tracheal intubation
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Background and Goal of Study: Spectral analysis of heart rate variability (HRV) may predict hypotensive effects of spinal anaesthesia and of
induction to general anaesthesia (1,2). The goal of this study was to investigate the relationship between preoperative values of HRV and hemodynamic responses to tracheal intubation.

**Materials and Methods:** Spectral analysis of HRV was assessed in 100 patients (TOM Signaltechnik, Hashiba & Niederl OEG, Graz, Austria) before induction of general anaesthesia (preoperative), after induction (pre-intubation) and after tracheal intubation (post-intubation). Fentanyl with propofol (Group I, n = 52) or with thipental (Group II, n = 48), followed with rocuronium, were given for induction. Absolute values of total power (TP), low and high frequency powers (LF and HF, respectively), and LF/HF ratio were analyzed. The highest percentage changes between pre- and post-intubation heart rates (d% HR) and mean arterial pressures (d% MAP), recorded by pulse oximetry and noninvasive measurements respectively, were correlated with the preoperative HRV (r-Pearson).

**Results and Discussions:** Demographic, HRV and hemodynamic preoperative data showed no significant differences. The significant positive correlations between d% HR and preoperative TP (r = 0.4984; p < 0.0001), LF (r = 0.4946; p < 0.0001) and HF (r = 0.3473; p < 0.001) but not LF/HF ratio (r = 0.0250; p = 0.851) were observed in all patients. The similar correlations were observed in Group I and II. We did not observe correlations between preoperative HRV values and d% MAP, probably due to different recording techniques of HR and MAP.

**Conclusion:** Preoperative HRV may be predictable for the increased heart rate response to tracheal intubation.

**References:**

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**A-157**

Decrease of postoperative heart rate variability may be related to the extensiveness of major surgery

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**Background and Goal of Study:** A persistent decrease of postoperative heart rate variability (HRV) has been reported to be independent of anesthetic technique and was observed in patients without cardiovascular diseases after noncardiac surgery (1). The goal of this study was to investigate the relationship between postoperative values of HRV and the extensiveness of surgery.

**Materials and Methods:** Spectral analysis of HRV was assessed in esophagectomized patients undergoing thoracotomy with laparotomy (Group I, n = 14) and in patients undergoing only laparotomy for total vtricle resection (Group II, n = 15). Holter recordings were performed before (1 and 3 days) and after surgery (2, 4, 6 days). Values of total power (TP), very low, low and high frequency powers (VLF, LF and HF, respectively) and LF/HF ratios were analyzed and compared as a percentage change of mean preoperative values (unpaired Student's t-test).

**Results and Discussions:** Demographic and HRV preoperative data showed no significant differences. Significant differences between both groups in postoperative HRV indices: TP (Figure), VLF, LF and HF, but not LF/HF ratio, were observed. The lowest values of HRV were observed in Group I and remained decreased on 6th postoperative day, while in Group II HRV values returned back to the preoperative level. The significant linear regression between duration of surgery and TP values in all patients on 6th postoperative day (r = −0.4986; p < 0.05) was observed.

**Conclusion:** The postoperative decrease in all HRV bands may be related to the extensiveness and duration of surgery.

**Reference:**

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**A-156**

Central neuraxial blockade increased the severity of hypotension due to mesenteric traction during major abdominal surgery

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**Background and Goal of Study:** Central neuraxial blockade (CNB) decreases cardiac output and frequently causes hypotension in general surgery. In this randomized study, we investigated that combined spinal and epidural (CSE) technique would increase severity of hypotension, induced by mesenteric traction (MT).

**Materials and Methods:** Fifty-five patients (n = 28, 27 in each group) undergoing major abdominal surgery, were administered either spinal anesthesia with bupivacaine 15 mg, followed by mepivacaine 100 mg through thoracic epidural anesthesia or intravenous 10 μg·kg⁻¹·min⁻¹ of fentanyl. General anesthesia was maintained with sevoflurane and phenylephrine was continuously infused for maintaining arterial pressure. A baseline measurement of anesthesia was maintained with sevoflurane and phenylephrine was continuously infused for maintaining arterial pressure. A baseline measurement of anesthesia was maintained with sevoflurane and phenylephrine was continuously infused for maintaining arterial pressure. A baseline measurement of anesthesia was maintained with sevoflurane and phenylephrine was continuously infused for maintaining arterial pressure.

**Results and Discussions:** There were no significant differences in MAP between both groups (90 ± 12 mmHg in CSE group vs. 97 ± 15 mmHg in fentanyl group). MAP significantly decreased at 10 min after MT in both groups, especially in CSE group (65 ± 15 mmHg vs. 82 ± 16 mmHg; P < 0.001). We considered that lower cardiac contractility due to CNB aggravated post-MT hypotension and prophylaxis for this phenomenon by ibuprofen would be needed when CNB was conducted.

**Conclusion(s):** CNB increased severity of MT-induced hypotension.
Background and Goal of Study: During regional anaesthesia applications to potentiate the effects of anaesthetic drug and to minimize the side effects of local anaesthetic, different adjuvants are added to local anaesthetics. Magnesium (Mg) is a noncompetitive N-Methyl-D-Aspartat (NMDA) antagonist and provides analgesia by preventing central sensitization developed by a nissipressive stimulation (1). In our study we aimed to observe an analgesic effect of intrathecal Mg and histopathologic changes in medulla spinalis.

Material and Method: After approval of the animal ethic committee 20 female rat between 240–260 gr weights selected randomly intrathecal catheter applied to the rats with anaesthesia and the day after they are separated into two groups. In the control group (Group K) (n = 10), for 4 days hot plate test performed for 2 hours period with 15 minutes intervals and the response time was recorded. In the magnesium group (Group M) (n = 10), for 4 days basal hot-plate test performed and then 0.02 mL (1.5% concentration) was given and for 2 hours period with 15 minutes intervals, hot plate test applied and response times were recorded. On the 5th day the medulla spinals of sacrificed rats examined pathologically. 2 samples are taken from formalized medulla spinalis of every rat and routine follow up procedures performed then 5 micro mL sections painted by hematoxilen eosin. “Axonal vacuolar degeneration”, “inflammation-necrosis”, “red neuron” histopathological parameters assessed by light microscope. The statistical analysis was made by independent sample t-test, paired sample t-test and chi-square test, p < 0.05 accepted as meaningful.

Results: Times for basal hot-plate test in the first day was not meaningful between groups (p < 0.05). On the other days all the measurement showed that hot-plate test times in Mg group was meaningfully long (p < 0.05). According to the histopatological examinations all the pathologic views between groups were not meaningful (p > 0.05).

Conclusion: The use of Mg in rats by intrathecally provided analgesia without increasing histopathological damage.

Reference:
A-162
Are ultra-short-acting beta-blockers useful to prevent hemodynamic changes during endotracheal intubation?
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Background and Goal of Study: Endotracheal intubation often causes undesirable hemodynamic changes. In this study, we examined the usefulness of ultra-short-acting beta-blockers, esmolol and lidocain, in comparison of fentanyl.

Materials and Methods: After institutional approval and written consent, 40 patients classified ASA I–II, 30–70-year-old, were randomly assigned to receive esmolol 1 mg (group E), lidocain 1 mg/kg (group L), fentanyl 3 μg/kg (group F) or none (group O) during repeated vital capacity induction with 7% of sevofluran in oxygen. Blood pressure (BP), heart rate (HR) were recorded during anesthetic induction. Stroke volume (SV) and cardiac output (CO) were also evaluated using BioZ™ Impedance Cardiography module (GE Healthcare IT Inc, USA). Serum noradrenalin concentration (NAD) was measured 1 min and 7 min after intubation.

Results and Discussions: There were no significant differences in patients’ background between groups. Although BP decreased to about 70% of pre-induction value, no significant difference was observed between groups until endotracheal intubation. In all groups, BP was significantly increased after intubation, while BP increase was significantly less in group F (P < 0.01); increase of systolic BP to the pre-intubation value: 177 ± 33% in group C, 153 ± 15% in group E, 136 ± 15% in group L and 118 ± 13% in group F. There was no significant difference in CO between groups after intubation. However, increase of NAD after intubation was suppressed to 124% of pre-intubation value in group F, while NAD increased to more than 300% in other groups.

Conclusion(s): Fentanyl significantly suppressed hemodynamic change and noradrenaline secretion during endotracheal intubation, although both esmolol and lidocain showed only tendency to suppress hemodynamic change.

A-164
Pivotal role for nitric oxide in isoflurane preconditioning-induced protection during cardiac ischemia/perfusion injury
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Background and Goal of Study: To establish the significance of isoflurane-induced early and delayed preconditioning (PC) on myocardial protection during ischemia and reperfusion (IR) injury and to elucidate the role of nitric oxide (NO) signaling pathway in this process.

Materials and Methods: A 30-min left coronary artery occlusion followed by 2-h reperfusion was used to develop IR injury in the anesthetized Sprague-Dawley rats. All rats undergo a pretreatment period consisting of either no intervention or preconditioning stimulus with two cycles of 3-min-ischemia followed by 10-min-reperfusion, 30 min of 1.4% isoflurane ischemia followed by a 10-min washout period, or received 60 min of 2.0% isoflurane ischemia 24 hours before IR. A nonselective NOS inhibitor L-NAME or selective iNOS inhibitor SMT was administered before or 24 h after ischemia, respectively. Myocardial infarct size was determined using triphenyltetrazolium staining.

Results and Discussions: Acute administration of isoflurane, similar to the protection of ischemic PC experiments, significantly decreased infarct size (acute ISO, 46 ± 3%; IPC, 38 ± 3%; as compared with control group 62 ± 4%). The infarct-sparing effect was also apparent in the delayed ischemic PC (35 ± 3%). L-NAME had no effect on infarct size when baseline addicted alone (59 ± 7%) or during acute isoflurane PC (39 ± 5%), but abolished the delayed preconditioning effect of isoflurane (57 ± 4%). The protection afforded by delayed ischemic PC was also abrogated when SMT was administered 24 h after ischemia (60 ± 2%). During delayed PC, cardiac level of nitrite and nitrate was significantly elevation at the end (24.6 ± 0.6 μM) and 24 h (29.1 ± 1.5 μM) after ischemia administration than control (15.7 ± 0.7 μM).

Conclusion(s): Isoflurane preconditioning confers both acute and delayed cardiac protection during IR injury that mimics the ischemic preconditioning phenomenon. The beneficial effect of isoflurane-induced delayed but not acute preconditioning depends on the release of NO in the heart. NO acts as a trigger initially and subsequently as a mediator (produced by iNOS) during isoflurane-induced delayed preconditioning.
A-167
Ischemic preconditioning attenuates myocardial stunning during minimally invasive direct coronary artery bypass grafting (MIDCAB)
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Department of Anästhesiologie, Klinik für Anästhesiologie und Operative Intensivmedizin, Kiel, Germany

Background and Goal of Study: A brief, controlled period of ischemia is able to exert cardioprotective properties due to a phenomenon called preconditioning [1]. During the MIDCAB-procedure the left anterior descending coronary artery (LAD) is clamped to enable anastomosis with the left internal mammary artery graft. Thus, depending on the degree of preexisting vessel occlusion, the myocardial tissue is rendered ischemic. A prior LAD clamping in terms of ischemic preconditioning may be advantageous in preserving left ventricular (LV) function. The myocardial performance index (MPI) derived from echocardiography is a sensitive tool for the assessment of LV function [2].

Materials and Methods: After IRB approval and written informed consent, 39 ASA III patients were randomly assigned to a standard (S, n = 20) or a preconditioning (P, n = 19) group. In both groups, anaesthesia was performed as total intravenous anaesthesia with propofol and remifentanil. Patients were anaesthetised and operated on always by the same anaesthesiologist and surgeon. In the preconditioning group, LAD was clamped for 2 minutes followed by a 3-minute period of reperfusion prior to definite clamping. Following induction of anaesthesia (baseline) and after definite LAD clamping, the MPI was analysed of-line by a blinded in-vestigator. Additionally, troponin T and CK-MB values were followed up to 72 hours after end of surgery. MPI data and biochemical values at baseline, during LAD clamping and after reperfusion were compared with ANOVA for repeated measures followed by appropriate post testing.

Results and Discussion: Demographic data and duration of LAD clamping (S = 15.4 min. vs P = 14.2 min.) were comparable in both groups. While there were no differences in biochemical markers of myocardial cell damage, the MPI declined significantly (p < 0.02) in the standard group during LAD clamping and reperfusion, whereas there was no change in the preconditioning group.

Conclusion(s): During LAD clamping myocardial function was better preserved after ischemic preconditioning. In contrast to the reported cardioprotective action of volatile anaesthetics, there was no effect with respect to myocardial cell damage.

References:

A-170
Sevoflurane induced preconditioning in men: 1 MAC for 5 min does not influence the phosphorylation of tyrosine kinase Src at Tyr 416
Department of Anästhesiologie, University Hospital of Duesseldorf, Duesseldorf, Germany

Background and Goal of Study: In ischaemic preconditioning, activation of tyrosine kinases (TK) is an essential step in signal transmission [1]). In anaesthetic induced preconditioning, the evidence regarding the role of TK is conflicting (2,3). We therefore investigated if TK are activated in men in right atrial samples after sevoflurane (Sevo-PC: 5 min, 1 MAC) administration before coronary artery bypass grafting (CPBG).

Materials and Methods: After approval by the local ethics committee and written informed consent, 20 Patients undergoing elective CABG were enrolled in this study. Both groups received a total intravenous anesthesia (TCI Propofol/Sufentanil). Ten patients were not further treated and served as control. In 10 patients, Sevo-PC was induced. Before and 10 min after Sevo-PC, or at the corresponding time point in controls, samples of right atrial tissue were taken and processed for Western Blot analysis of phosphorylated Src-TK (Tyrosine 416). After measurement of the mean light intensity for each sample, and normalization to actin the ratio of phosphorylation after Sevo-PC or at the corresponding time point in controls to baseline sample was calculated. Data are mean ± SEM; Statistics: paired t-test for repeated measurements.

Results and Discussions: In both groups phosphorylation of Src-TK at Tyr 416 was not affected (see Figure).

A-169
Prebypass preconditioning with sevoflurane has no effect on postoperative myocardial cell damage
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Background and Goal of Study: Volatile anaesthetics were shown to exert cardioprotective properties depending on a phenomenon termed preconditioning [1]. There is an ongoing debate about timing and dosage of volatile anaesthetics and if continued administration during cardiopulmonary bypass (CPB) is clamped to enable anastomosis with the left internal mammary artery graft. Thus, depending on the degree of preexisting vessel occlusion, the myocardial tissue is rendered ischemic. A prior LAD clamping in terms of ischemic preconditioning may be advantageous in preserving left ventricular (LV) function. The myocardial performance index (MPI) derived from echocardiography is a sensitive tool for the assessment of LV function [2].

Materials and Methods: After IRB approval and written informed consent, 19 ASA III patients were randomised to standard (S, n = 10) or preconditioning (P, n = 9) group. In both groups, anaesthesia was induced as total intravenous anaesthesia with propofol and remifentanil (TIVA). Subsequently, in the preconditioning group, sevoflurane was administered aiming at a BIS value of 40–60 and for 10 minutes prior to initiation of CPB at least 1 MAC. Sevoflurane was stopped directly before CPB. In the TIVA group, propofol dosing was guided according to BIS. Pre-BNP, Troponin T and CK-MB values were followed for up to 72 hours after end of surgery. Laboratory values were compared with two way ANOVA for repeated measures followed by appropriate post testing.

Results and Discussions: Time on bypass, duration of aortic cross clamp, total time of surgery and demographic data were not statistically different. In addition there were no differences in laboratory markers of myocardial cell damage.

Conclusion(s): Anaesthetic preconditioning before cardiopulmonary bypass had no impact on postoperative myocardial cell damage. This emphasizes the significant influence of timing on the effect of anaesthesia related myocardial protection.

References:
A-171
Desflurane induces a first and second window of anesthetic preconditioning against myocardial infarction
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Background and Goal of Study: In ischemic preconditioning (IPC) one short ischemic stimulus induces early and late preconditioning. These time windows are separated by an intervening time interval without cardioprotection. We tested the hypothesis that a 30-min administration of desflurane induces both early and late preconditioning separated by a time interval of 0.5 h.

Results and Discussions: Hemodynamic changes analysis in rabbits submitted to hemorrhage and pneumoperitoneum. Components have been shown to be valuable tools for hemodynamic analysis. SPV and its components, vital signs and ABG were measured at four moments: baseline (T1), after 10 mmHg PMOP (T2), after controlled hemorrhage of 20% of the estimated volume under general anesthesia, were studied. SPV and its components, vital signs and ABG were measured at four moments: baseline (T1), after 10 mmHg PMOP (T2), after controlled hemorrhage of 20% of the estimated volume under general anesthesia, were studied. SPV and its components, vital signs and ABG were measured at four moments: baseline (T1), after 10 mmHg PMOP (T2), after controlled hemorrhage of 20% of the estimated volume under general anesthesia, were studied.

Data (mean ± SEM).

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>PMOP</th>
<th>PMOP + hemo</th>
</tr>
</thead>
<tbody>
<tr>
<td>HR (bpm)</td>
<td>219 ± 29</td>
<td>236 ± 24</td>
<td>245 ± 30</td>
</tr>
<tr>
<td>MAP (mmHg)</td>
<td>55 ± 15</td>
<td>69 ± 16</td>
<td>62 ± 17</td>
</tr>
<tr>
<td>Lung Compl. (ml/cmH2O)</td>
<td>2.5 ± 0.7</td>
<td>1.5 ± 0.3</td>
<td>1.5 ± 0.5</td>
</tr>
<tr>
<td>SPV (mmHg)</td>
<td>8.5 ± 1.6</td>
<td>13.3 ± 2.6</td>
<td>19.9 ± 3.7</td>
</tr>
<tr>
<td>Δ up (mmHg)</td>
<td>2.0 ± 1.0</td>
<td>6.7 ± 2.1</td>
<td>5.9 ± 1.6</td>
</tr>
<tr>
<td>Δ down (mmHg)</td>
<td>6.4 ± 1.6</td>
<td>6.6 ± 3.3</td>
<td>14.0 ± 4.9</td>
</tr>
<tr>
<td>pH (SD: ±0.04)</td>
<td>7.43</td>
<td>7.40</td>
<td>7.37</td>
</tr>
<tr>
<td>PaCO2 (mmHg)</td>
<td>42 ± 3</td>
<td>47 ± 3</td>
<td>48 ± 3</td>
</tr>
<tr>
<td>PaO2 (mmHg)</td>
<td>401 ± 88</td>
<td>362 ± 97</td>
<td>367 ± 109</td>
</tr>
<tr>
<td>Hematocrit (%)</td>
<td>25.6 ± 2.9</td>
<td>26.7 ± 2.5</td>
<td>23.1 ± 3.0</td>
</tr>
</tbody>
</table>

Data (mean ± SD) are shown in the Table (P < 0.05).

Conclusion: SPV and its components were shown to be sensitive tools for hemodynamic changes analysis in rabbits submitted to hemorrhage and pneumoperitoneum.

References:

Acknowledgements: FAPESP 03/12988-8.

A-174
Systolic pressure variation is a sensitive method to detect hemodynamic changes during pneumoperitoneum. An experimental study
F. Blacheriennien, J.O.C. Auler Jr., E.B. Fonseca, S. Blacheriennien
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Background and Goal of Study: Systolic pressure variation (SPV) and its components have been shown to be valuable tools for hemodynamic analysis. SPV and its components, vital signs and ABG were measured at four moments: baseline (T1), after 10 mmHg PMOP (T2), after controlled hemorrhage of 20% of the estimated volume under general anesthesia, were studied. SPV and its components, vital signs and ABG were measured at four moments: baseline (T1), after 10 mmHg PMOP (T2), after controlled hemorrhage of 20% of the estimated volume under general anesthesia, were studied. SPV and its components, vital signs and ABG were measured at four moments: baseline (T1), after 10 mmHg PMOP (T2), after controlled hemorrhage of 20% of the estimated volume under general anesthesia, were studied.

Results:

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
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<tr>
<td>SPV (mmHg)</td>
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<td>pH (SD: ±0.04)</td>
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</tr>
</tbody>
</table>

Data (mean ± SD) are shown in the Table (P < 0.05).

Conclusion: SPV and its components were shown to be sensitive tools for hemodynamic changes analysis in rabbits submitted to hemorrhage and pneumoperitoneum.

References:

Acknowledgements: This study was supported in part by funds from the IZKF, Wuerzburg and Baxter, Germany.
consisted of recordings of electrocardiographic and LV pressure tracings during an increase in systolic and diastolic pressures, obtained by leg elevation. Measurements were obtained before and after ANH. Arterial and mixed venous blood gases were taken before and after ANH. Data were compared using a paired t-test. All data (mean ± SD) were considered significant if p < 0.01.

**Results:** ANH resulted in a significant decrease in hematocrit (Hct) from 40 ± 4 to 29 ± 2% after ANH, CO increased significantly from 5.3 ± 1.3 to 5.6 ± 1.22/min. This was associated with a significant decrease in systemic vascular resistance from 905 ± 182 to 757 ± 123 dynes/sec/cm². With ANH, oxygen delivery significantly decreased from 953 ± 245 to 811 ± 153 ml/dl. Oxygen consumption was similar before and after ANH, hence oxygen extraction ratio increased significantly from 15 ± 2 to 19 ± 2%. Compared to before ANH, the increase in dP/dtmax with leg elevation was significantly lower after ANH (48 ± 32 before ANH versus 11 ± 22 mmHg after ANH). The rate of isovolumic relaxation (s) significantly increased from 60 ± 5 to 64 ± 5 ms with ANH. The change in τ with leg elevation was significantly accelerated before and after ANH (−2 ± 2 versus 2 ± 3 ms).

**Conclusion:** Despite an increase in CO after ANH, myocardial function seemed to be depressed as evident from a slower myocardial relaxation and a decreased response in dP/dtmax with an increased cardiac load.

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**A-175**

**Effects of acute isovolemic hemodilution under total intravenous anesthesia on left ventricular function in cardiac surgery patients**

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**Background:** Preservation of tissue oxygenation during acute isovolemic hemodilution (ANH) depends on an increase in cardiac output (CO) and an increase in blood oxygen extraction. However, the precise effects of ANH during total intravenous anesthesia on left ventricular function have not yet been determined in cardiac patients.

**Materials and Methods:** 13 elective coronary surgery patients received a midazolam based anesthesia. After aortic cannulation a pressure micro-manometer was inserted in the left ventricle (LV). The measurements consisted of recordings of electrocardiographic and LV pressures tracings during an increase in systolic and diastolic pressure, obtained by leg elevation. Measurements were obtained before and after ANH. Arterial and mixed venous blood gases were taken before and after ANH. Data were compared using a paired t-test. All data (mean ± SD) were considered significant if p < 0.01.

**Results:** ANH resulted in a significant decrease in hematocrit (Hct) from 40 ± 4 to 29 ± 4%. After ANH, CO increased significantly from 5.6 ± 1.1 to 6.7 ± 1.31/min. This was associated with a significant decrease in systemic vascular resistance from 908 ± 166 to 780 ± 160 dynes/sec/cm². With ANH, oxygen delivery significantly decreased from 987 ± 191 to 830 ± 141 ml/dl. Oxygen consumption was similar before and after ANH, hence oxygen extraction ratio increased significantly from 16 ± 1 to 20 ± 1%. Compared to before ANH, the increase in dP/dtmax with leg elevation was significantly lower after ANH (60 ± 40 before ANH versus 23 ± 33 mmHg after ANH). The rate of isovolumic relaxation (s) significantly increased from 60 ± 7 to 64 ± 6 ms with ANH. The change in τ with leg elevation was also significantly different before and after ANH (−1 ± 1 versus 2 ± 1 ms).

**Conclusion:** Despite an increase in CO after ANH, myocardial function seemed to be depressed as evident from a slower myocardial relaxation and a decreased response in dP/dtmax with an increased cardiac load.

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**A-176**

**Anesthesia for left ventricular assist device placement: preoperative risk factors for right ventricular failure after device insertion**

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**Background and Goal of Study:** The major concern on weaning from cardiopulmonary bypass after left ventricular device (LVAD) placement is right ventricular (RV) failure. This complication has a poor prognosis and is generally unpredictable. Prediction of RV failure after LVAD insertion would lead to optimal patient selection and more ready anesthesiologic management.

**Materials and Methods:** From 1992 to 2003, 51 Novacor™ N100 LVADs were implanted in our Hospital. In order to determine preoperative risk factors for RV failure developing, we compared patient preoperative characteristics and hemodynamics in the group that developed RV failure in the first 24 h after LVAD insertion and in the group that did not develop RV failure. The RV failure group presents low LVAD pump flow index (<2.0L/min/m²) with inotropic support and tricuspid regurgitation at transesophageal echocardiography monitoring. These patients required vasopressors, nitric oxide inhalation, and/or right ventricular assist device.

**Results and Discussions:** There was no significant difference between the groups in demographic and hemodynamic characteristic. Mean and standard deviation (between round brackets) of the variables significantly different are summarized in the Table.

<table>
<thead>
<tr>
<th>Variable</th>
<th>RV failure 15pts</th>
<th>No RV failure 36pts</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>BSA (m²)</td>
<td>1.86 (0.14)</td>
<td>1.79 (0.13)</td>
<td>0.07</td>
</tr>
<tr>
<td>BUN (mg/dl)</td>
<td>92.2 (3.6)</td>
<td>65.7 (3.4)</td>
<td>0.02</td>
</tr>
<tr>
<td>Creatinin (mg/dl)</td>
<td>1.7 (0.5)</td>
<td>1.3 (0.4)</td>
<td>0.01</td>
</tr>
<tr>
<td>Bilirubin (mg/dl)</td>
<td>2.8 (0.9)</td>
<td>1.9 (0.7)</td>
<td>0.06</td>
</tr>
<tr>
<td>AST (U/L)</td>
<td>635 (13.4)</td>
<td>63 (10.1)</td>
<td>0.026</td>
</tr>
<tr>
<td>ALT (U/L)</td>
<td>590 (10.1)</td>
<td>120.6 (3.2)</td>
<td>0.026</td>
</tr>
</tbody>
</table>

BSA = body surface area; BUN = blood urea nitrogen; AST = aspartate aminotransferase; ALT = alanine aminotransferase.

**Conclusion(s):** Preoperative severe impairment of liver and renal functions and low body surface area were significant predictors for RV failure development after LVAD insertion. This information may lead to better patient selection for isolated LVAD implantation.

**References:**

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**A-177**

**Effect of nitrotyrosine on α-adrenergic receptor mediated vascular reactivity in rats**

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Department of Anesthesiology, College of Medicine and Zhongda Hospital, South, Nanjing, China

**Background and Goals:** To observe the effects of 3-nitro-L-tyrosine (3-NT) on adrenergic receptor mediated vascular reactivity in rats and investigate its possible mechanism.

**Material and Methods:** 24 male SD rats were randomly divided into 2 groups: the control group (intravenous administration of saline, n = 12), and the 3-NT group (intravenous administration of 3-NT 2.5 µmol/kg, n = 12). After 30 minutes and 90 minutes, apply Phenylephrine (0.5 – 2.5 µg·kg⁻¹) and vasopressin (1.3 – 5.2 µg·kg⁻¹) intravenously to both groups and record the percentage increased in MAP respectively. The rings of aorta from another 6 male SD rats were incubated for 60 min in Krebs buffer, dose-response curve were obtained by cumulative addition of PE (1 x 10⁻⁹ – 3 x 10⁻³mol/L). After five washes, again divide the samples into the repeat control group (Krebs Ringer Solution) and the 3-NT group (250 µmol 3-NT). After 60 minutes of incubation, reapply PE to both groups and record the response of tissue. Data represent Mean ± SD. Significance was defined as p < 0.05.

**Results:** Compared with control group, application of 3-NT (2.5 µmol · kg⁻¹) significantly inhibited the MAP increase induced by phenylephrine with time-dependent way, but it did not affect the MAP level induced by vasopressin. In the vascular tension experiment, no significant differences were observed between the control group and 3-NT group in dose-response curve, E_max and EC₅₀ values to PE.
A-178
Non-invasive assessment of the impact of increasing concentrations of isoflurane on cardiac performance in mice
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Background and Goal of Study: Echocardiography allows for sensitive, non-invasive assessment of cardiac function in mice, but requires sedation and immobilization, which influences cardiac performance. We studied the effects of increasing levels of isoflurane on cardiac performance.

Materials and Methods: 18 C57-B/6 mice were studied at 3 levels of isoflurane: 0.875%, 1.75% and 3.5%. Cardiac performance was measured at baseline condition (B), after dobutamine, 2 mg/kg ip (D) and after esmolol, 40 mg/kg ip (E) using a high-resolution ultrasound system. Stroke volume (SV, µL) was assessed by Doppler in the aortic outflow tract and fractional shortening (FS) by M-mode in the short axis view. Cardiac output (CO; mL/min) was calculated as SV*HR. Data are presented as mean ± SD; ANOVA was used for statistical analysis.

Results and Discussions: Isoflurane decreased cardiac function in a concentration-dependent fashion (see Table).

<table>
<thead>
<tr>
<th>Condition</th>
<th>HR</th>
<th>FS</th>
<th>SV</th>
<th>CO</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.875% B</td>
<td>518 ± 17</td>
<td>42 ± 5</td>
<td>45 ± 8</td>
<td>24 ± 4</td>
</tr>
<tr>
<td>0.875% D</td>
<td>537 ± 9</td>
<td>58 ± 3</td>
<td>46 ± 7</td>
<td>25 ± 4</td>
</tr>
<tr>
<td>1.75% E</td>
<td>356 ± 15*</td>
<td>28 ± 3*</td>
<td>41 ± 6</td>
<td>15 ± 2*</td>
</tr>
<tr>
<td>1.75% D</td>
<td>427 ± 29</td>
<td>30 ± 4</td>
<td>55 ± 18</td>
<td>23 ± 7</td>
</tr>
<tr>
<td>1.75% E</td>
<td>501 ± 15*</td>
<td>53 ± 1*</td>
<td>62 ± 14</td>
<td>31 ± 7</td>
</tr>
<tr>
<td>3.5% E</td>
<td>356 ± 20*</td>
<td>28 ± 3*</td>
<td>46 ± 10</td>
<td>16 ± 3*</td>
</tr>
<tr>
<td>3.5% D</td>
<td>457 ± 39</td>
<td>34 ± 5*</td>
<td>37 ± 3*</td>
<td>17 ± 3</td>
</tr>
<tr>
<td>3.5% E</td>
<td>439 ± 33*</td>
<td>45 ± 5*</td>
<td>38 ± 8*</td>
<td>16 ± 3*</td>
</tr>
<tr>
<td>3.5% E</td>
<td>275 ± 67*</td>
<td>7</td>
<td>8</td>
<td></td>
</tr>
</tbody>
</table>

*P < 0.05 vs Baseline; ^P < 0.05 vs Dobutamine; #P < 0.05 vs Iso 0.875; ^#P < 0.05 vs Iso 1.75.

Increasing isoflurane depressed cardiac performance at baseline, but responses to D were preserved at 1.75%. At 3.5%, responses to D were decreased, and E caused decompensation, suggesting exhaustion of sympathetic reserve.

Conclusions: Non-invasive ultrasound proved to be a sensitive tool to detect changes in cardiac performance. Isoflurane depresses cardiac function in a dose-related fashion in mice. Sympathetic responses compensate, but reserve is limited.

A-179
Pulsed pressure variation and stroke volume variation: predictive parameters of response to a fluid challenge in coronary-artery surgery
M. Gourdin, C. Dransart, M. Lameir, A. Evans, J. Jamart, E. Collard
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Background and Goal of Study: The pulsed pressure variation (PPV) and stroke volume variation (SVV) derived from the pulse contour analysis are proposed as predictive parameters of response to fluid challenge in a closed-chest situation (1,2). In this study, we investigated the applicability of these parameters in an open-chest situation in patients undergoing elective coronary-artery bypass grafting surgery (CABG).

Materials and Methods: After informed consent, 24 patients with ejection fraction >45%, sinus rhythm and without valvulopathy were monitored using a continuous pulse contour based cardiac output monitor (PICCO, Pulson, Germany). Anaesthesia was induced and maintained with propofol, sufentanil and cisatracurium. The patients were ventilated with a FiO2 of 0.5 in air, a tidal volume of 6 ml/kg and a respiratory rate of 12/min. Two fluid challenges (5 ml/kg of saline) were performed: 10 min. after induction of anaesthesia (closed-chest) and 5 min. after sternotomy prior the opening of the pericardium. The PPV, SVV and cardiac index (CI) were noted at the beginning and 1 min. after the end of the fluid challenge. Correlation between PPV or SVV and ΔCI (CI post test minus CI pre-test) were assessed by Spearman rank correlation coefficient.

Results and Discussions: The mean age, weight and height were respectively 72 ± 8 years, 77 ± 12 kg and 175 ± 15 cm. The correlations between pre-test PPV or SVV and ΔCI were positive after fluid challenges. In an open-chest situation, the pre-test PPV-ΔCI correlation seems to be better than the pre-test SVV-ΔCI correlation.

A-180
Relationship between preload dependency and tissue perfusion during aortic surgery
M. Boulo, M. Fleyfel, E. Robin, G. Lebuffe, B. Vallet
Department of Anaesthesiology and Intensive Care Medicine in Cardio, Hôpital Cardiologique CHR U, Lille, France

Introduction: Aortic surgery leads to volume status variation and hemodynamic impairment. In intubated and ventilated patients, respiratory pulse pressure variation (ΔPP) reflects ventricular preload dependency (1). ΔPP is a good predicting marker of increase in stroke volume index (SVI) after a fluid challenge (2). The aim of the study was to evaluate whether preload dependency assessed by ΔPP measurement was associated with impaired tissue perfusion.

Methods: After approval from the local Ethics Committee, 15 patients undergoing aortic surgery were prospectively enrolled. Intraoperative hypovolemia was suspected when heart rate increased and/or systolic blood pressure dropped more than 20% from baseline. A 250 mL colloidal FC was performed and repeated until delta PAPO was less than 2 mmHg. Automated gastric tonometry (Tonocap®, Datex-Ohmeda, Finland) was used to assess PtpCO2-PetCO2 before and after FC (CO2gap1, CO2gap2). An increased CO2gap larger than 20 mmHg was taken as a threshold value of decreased tissue perfusion. A test of Pearson for correlation analysis, and a test of Wilcoxon for comparison between CO2gap1 and CO2gap2 measurements were performed.

Results: 85 FC were studied. There was a significant correlation between ΔPP and SVI variation: 0.748 (p < 0.0001). There was no correlation between ΔPP and CO2gap1 (rho = –0.08; p = 0.843) and no significant difference CO2gap1 and CO2gap2: 14 mmHg (8.5–19) vs 13.5 [10–20] (p = 0.824).

Conclusion: In patients undergoing aortic surgery, preload dependency may not be equivalent to decreased tissue perfusion.

References:

A-181
Nitric oxide but not EDHF is important for hypercapnia induced coronary vasodilation in mice
A. Heintz, M. Brand, S. Stehr, M. Höbler, A. Deussens, T. Koch
Department of Anaesthesiology, University Hospital, Dresden, Germany

Background and Goal of Study: Endothelial mediators have been suggested to contribute to coronary vasodilation. In the present study the potential importance of NO and EDHF during hypercapnic acidosis was addressed.

Materials and Methods: Isolated mouse hearts were perfused (90 mmHg) with modified Krebs–Henseleit buffer. Hypercapnic acidosis was induced by switching from control perfusate (pCO2 = 37 mmHg, pH = 7.34) to hypercapnic buffer (pCO2 = 61 mmHg, pH = 7.15).

Results and Discussions: 5 min perfusion with hypercapnic buffer enhanced coronary flow by 42%, reduced left ventricular pressure development (LVD)
Clinical and experimental circulation

by 13% and reduced myocardial oxygen consumption by 20%. Infusion of L-NMMA (100 μmol/l) to block NO-synthesis reduced coronary flow by 15%. In the presence of L-NMMA hypercapnic perfusion was associated with a reduced flow increase (22%). Additional infusion of TEA (1 μmol/l) to block Ca²⁺-dependent K⁺-channels was associated with a slight increase of coronary flow and LVD. However, the hypercapnia-related flow increase was not further reduced. In contrast, acetylecoline (0.5 μM) induced flow increase was decreased in the presence of L-NMMA and in the additional presence of TEA.

Conclusions: NO is important for the mediation of hypercapnic coronary dilation in mouse heart. While K⁺-channels are involved in the mediation of cholinergic coronary dilation, they are unimportant for hypercapnic vasodilation.

Results and Discussion:

Table 1. Biological variables at 135 min.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Fed</th>
<th>Fasting</th>
</tr>
</thead>
<tbody>
<tr>
<td>AST (IU/l)</td>
<td>120 ± 25</td>
<td>826 ± 479</td>
</tr>
<tr>
<td>ALT (IU/l)</td>
<td>74 ± 27</td>
<td>787 ± 621</td>
</tr>
<tr>
<td>LDH (IU/l)</td>
<td>1,153 ± 325</td>
<td>9,745 ± 3,716</td>
</tr>
<tr>
<td>Glucose (mg/dl)</td>
<td>253 ± 40</td>
<td>84 ± 38</td>
</tr>
<tr>
<td>Lactate (mg/dl)</td>
<td>60 ± 8.5</td>
<td>3.9 ± 3.6</td>
</tr>
<tr>
<td>Cyt c (ng/ml)</td>
<td>7.2 ± 0.7</td>
<td>50.8 ± 32.7</td>
</tr>
<tr>
<td>Dienes (%OI)</td>
<td>0.34 ± 0.05</td>
<td>0.42 ± 0.03</td>
</tr>
<tr>
<td>Trienes (%OI)</td>
<td>0.16 ± 0.02</td>
<td>0.21 ± 0.02</td>
</tr>
<tr>
<td>Glycogen (%)</td>
<td>40.5 ± 33.7</td>
<td>6.0 ± 2.6</td>
</tr>
</tbody>
</table>

Livers of fasting rats are more sensitive to warm IR injury than livers from fed animals. Reduced glycogen stores in hepatocytes is related to the reduced tolerance. Mitochondrial damage, demonstrated by the release of cytochrome c, may contribute to amplify the deleterious effect of glycogen depletion.

Conclusion: In clinical conditions where livers are exposed to a temporary oxidative stress, nutritional support may be part of a treatment strategy.

References:


A-182
Pulmonary artery perfusion during cardiopulmonary bypass improves postoperative gas exchange in a swine model

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Background and Goal of Study: Respiratory dysfunction occurs in virtually all patients undergoing cardiopulmonary bypass (CPB) and it has been recognized that CPB is cause of pulmonary ischemic-reperfusion injury (2). We hypothesized that hypothermic perfusion of the pulmonary artery by oxygenated blood during CPB would have a protective effect and can attenuate the deterioration of lung function after CPB.

Materials and Methods: After governmental approval 17 pigs underwent CPB for 60 min. The animals were assigned prospectively and randomizedly to 3 groups (n = 5): one had free access to food, the latter was fasted for 18 hours. The portal vein was cannulated, and the content of neutrophiles in the right atrium (PMN) were evaluated and compared to baseline (Wilcoxon-test). Group differences were estimated by Mann-Whitney-U-test, level of significance was p < 0.05.

Results and Discussions: Compared to baseline AsA/D2O increased in either group after discontinuation of CPB with significantly higher values after 120 and 180 min in control. PMN dropped significantly only in PP immediately after CPB. PCWP remained nearly unchanged after CPB independently of the group.

Conclusion(s): Pulmonary function after CPB can be ameliorated by hypothermic pulmonary artery perfusion with oxygenated blood. The decrease in PMN might indicate an attenuation of the inflammatory response.

References:


A-183
Effect of nutritional status on oxidative stress in an ex vivo perfused rat liver

M. Stadler, V. Nuyens, J. Boogaerts
Department of Anaesthesiology, University Hospital Centre Charleroi, Charleroi, Belgium

Background: Ischaemia-reperfusion (IR) is a determinant in liver injury occurring during surgical procedures, ischaemic state and multiple organ failure. The preexisting nutritional status of the liver might contribute to the extend of tissue alteration and primary non-function.1,2 The aim of this study was to determine the role of starvation on hepatic IR injury in normal rat livers.

Methods: Rats were divided into two groups (n = 5): one had free access to food, the latter was fasted for 18 hours. The portal vein was cannulated, and the content of neutrophiles in the right atrium (PMN) were evaluated and compared to baseline (Wilcoxon-test). Group differences were estimated by Mann-Whitney-U-test, level of significance was p < 0.05.

Results and Discussion: Results are presented in Table 1. No difference was observed in lactate level. The glycogen content was low in all livers and decreased at 135 min in the control group only (P = 0.05).

Results and Discussion:

Table 1. Biological variables at 135 min in the perfusate.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Control</th>
<th>IL 10 μg/mL</th>
<th>IL 100 μg/mL</th>
</tr>
</thead>
<tbody>
<tr>
<td>AST (IU/L)</td>
<td>826 ± 479</td>
<td>356 ± 152</td>
<td>172 ± 36*</td>
</tr>
<tr>
<td>ALT (IU/L)</td>
<td>787 ± 612</td>
<td>312 ± 153</td>
<td>63 ± 18*</td>
</tr>
<tr>
<td>LDH (IU/L)</td>
<td>9,745 ± 3,716</td>
<td>6,103 ± 3,048</td>
<td>1,875 ± 566*</td>
</tr>
<tr>
<td>Glucose (mg/dl)</td>
<td>9.3 ± 0.8</td>
<td>8.6 ± 0.2</td>
<td>7.7 ± 0.3*</td>
</tr>
<tr>
<td>Cyt c (ng/ml)</td>
<td>50.8 ± 32.7</td>
<td>11.9 ± 4.9*</td>
<td>9.2 ± 1.7</td>
</tr>
<tr>
<td>Dienes (%OI)</td>
<td>0.40 ± 0.03</td>
<td>0.35 ± 0.04b</td>
<td>0.29 ± 0.04b</td>
</tr>
<tr>
<td>Trienes (%OI)</td>
<td>0.20 ± 0.02</td>
<td>0.19 ± 0.04</td>
<td>0.15 ± 0.01</td>
</tr>
</tbody>
</table>

* P < 0.05 when compared with control and IL 10 μg/mL.

IL presents a protective effect on IR injury demonstrated by the reduction of enzymes, K⁺, free radicals, and cytochrome c release in the perfusate.

Conclusion: In a clinical setting, the infusion of IL may be indicated to compensate fasting in surgical patients and thus might improve outcome after liver surgery and transplantation.

Reference:

A-185
Protective effect of alanine on ex vivo perfused rat liver during ischaemia-reperfusion
M. Stadler, V. Nuyens, J. Boogaerts
Department of Anaesthesiology, University Hospital Centre Charleroi, Charleroi, Belgium

Background: Glycogen seems to protect hepatocytes against ischaemia-reperfusion (IR) injury whereas fasting increases lipid peroxidation. Alanine (Ala) has shown to improve survival of liver cells exposed to oxidative stress. This study investigated whether Ala could protect the liver after IR injury in food deprived rats.

Materials and Methods: Wistar rats (150–200 g) fasted for ≥18 hours were anaesthetised, the portal vein cannulated, the liver removed and immediately perfused (5 ml/min, 37°C, closed ex vivo system with HBSS + insulin and O2). The 3 experimental phases: perfusion for 15 min, warm ischaemia for 60 min, and reperfusion during 60 min. Animals were divided into 5 subgroups (n = 5): control (glucose 1 g/l), and Ala groups at 1, 5, 10 and 25 g/l, without glucose. Glucose, lactate, enzymes, dienes and trienes and cytchrome c were analysed in perfusate from 0 to 135 min. The proportion of glycogen in hepatocytes was determined in biopsies. Mean ± SD. GLMM statistic and Student t test for Bonferroni corrections.

Results and Discussion:

Table 1. Numbers at final time-point, i.e. 135 min.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Control</th>
<th>Ala 1 g/l</th>
<th>Ala 5 g/l</th>
<th>Ala 10 g/l</th>
<th>Ala 25 g/l</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lact (mg/dl)</td>
<td>3.9 ± 3.6</td>
<td>5.0 ± 7.6</td>
<td>4.2 ± 1.0</td>
<td>8.0 ± 6.0</td>
<td>6.2 ± 1.0</td>
</tr>
<tr>
<td>AST (IU/l)</td>
<td>716 ± 104</td>
<td>600 ± 294</td>
<td>53 ± 272</td>
<td>150 ± 28 ± 14</td>
<td>150 ± 28 ± 14</td>
</tr>
<tr>
<td>ALT (IU/l)</td>
<td>570 ± 69</td>
<td>302 ± 147</td>
<td>373 ± 178</td>
<td>80 ± 34 ± 11</td>
<td>139 ± 64 ± 12</td>
</tr>
<tr>
<td>LDH (IU/l)</td>
<td>1273 ± 1432</td>
<td>11203 ± 9586</td>
<td>6943 ± 3033</td>
<td>1751 ± 56 ± 16</td>
<td>1659 ± 690 ± 30</td>
</tr>
<tr>
<td>Dienes (% OI)</td>
<td>43 ± 3</td>
<td>33 ± 6</td>
<td>31 ± 4</td>
<td>24 ± 4</td>
<td>20 ± 3 ± 1</td>
</tr>
<tr>
<td>Trienes (% OI)</td>
<td>0.2 ± 0.02</td>
<td>0.18 ± 0.01</td>
<td>0.16 ± 0.02 ± 11</td>
<td>0.14 ± 0.02 ± 11</td>
<td>0.11 ± 0.01 ± 8</td>
</tr>
<tr>
<td>Cyt c (ng/ml)</td>
<td>50.8 ± 32.7</td>
<td>93.0 ± 0.3</td>
<td>7.1 ± 0.9</td>
<td>7.8 ± 0.4</td>
<td>5.3 ± 0.5</td>
</tr>
<tr>
<td>Glycogon (%)</td>
<td>6.0 ± 2.6</td>
<td>10.9 ± 8.9</td>
<td>14.5 ± 6.4</td>
<td>7.8 ± 4.0</td>
<td>10.4 ± 1.4</td>
</tr>
</tbody>
</table>

P < 0.05 vs control or others; tAla 1 g/l vs others; tAla 5 g/l vs others.

A-186
Effect of general anesthesia on apoptosis, proliferation and responsiveness to angiotensin II of renal mesangial cells from rats with experimental renal failure
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Department of Anesthesiology, Assaf Harofeh Medical Center, Zefen, Israel

Background and Goal of Study: Transient decline of blood pressure and GFR, following induction of general anesthesia, affects autoregulatory functions of renal glomerular mesangium. Patients with chronic renal failure are more susceptible to AII and augmented apoptotic death of cultured renal mesangium. Heme oxygenase-1 induction improves pancreatic microcirculation after ischemia/reperfusion in rats. The goal of this experiment was to investigate the biological effect of 2 or 10 minutes IPC in an ex vivo perfused rat liver after oxidative stress.

Materials and Methods: Female Wistar rats (150–200 g) fasted for ≥18 hours were anaesthetised, the portal vein cannulated, the liver removed and immediately perfused (5 ml/min, 37°C, closed ex vivo system with HBSS + insulin and O2). The experiment consisted of different phases: in the group control, perfusion 15 min, warm ischaemia for 60 min, and reperfusion during 60 min; in the IPC groups 2 or 10 min ischaemia during the first 15 min, followed by a period of reperfusion called ischaemic preconditioning (IPC) have been shown to protect organs against subsequent sustained ischaemia. The goal of this experiment was to investigate the biological effect of 2 or 10 minutes IPC in an ex vivo perfused rat liver after oxidative stress.

Results and Discussion: 10 min IPC decreases transaminases release (Table 1). Cytochrome c was lower in the IPC groups.

A-187
Ischaemic preconditioning on oxidative stress in an ex vivo perfused rat liver
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Department of Anaesthesiology, University Hospital Centre Charleroi, Charleroi, Belgium

Background: Ischaemia-reperfusion is a major cause of morbidity and mortality in liver surgery and transplantation. Brief episodes of ischaemia followed by a period of reperfusion called ischemic preconditioning (IPC) have been shown to protect organs against subsequent sustained ischaemia. The goal of this experiment was to investigate the biological effect of 2 or 10 minutes IPC in an ex vivo perfused rat liver after oxidative stress.

Materials and Methods: Female Wistar rats (150–200 g) fasted for ≥18 hours were anaesthetised, the portal vein cannulated, the liver removed and immediately perfused (5 ml/min, 37°C, closed ex vivo system with HBSS + insulin and O2). The experiment consisted of different phases: in the group control, perfusion 15 min, warm ischaemia for 60 min, and reperfusion during 60 min; in the IPC groups 2 or 10 min ischaemia during the first 15 min, followed by warm ischaemia and reperfusion as in the control group. Glucose, lactate, enzymes, free radicals (dienes and trienes) and cytchrome c were analysed in perfusate at different time-points from 0 to 135 min. The proportion of glycogen in hepatocytes was determined in biopsies. Mean ± SD. GLMM statistics and Student t test for Bonferroni corrections.

Results and Discussion: 10 min IPC decreases transaminases release (Table 1). Cytochrome c was lower in the IPC groups.

A-188
Heme oxygenase-1 induction improves pancreatic microcirculation after ischemia/reperfusion in rats
Department of Anaesthesiology, University Hospital, Freiburg, Germany

Background and Goal of Study: Microcirculatory derangements caused by ischemia/reperfusion (IR) play a pivotal role in acute and graft pancreatitis (1,2). The inducible isofrom of heme oxygenase (HO-1) has been shown to improve survival of liver cells exposed to oxidant stress. Alanine (Ala) has shown to improve survival of liver cells exposed to oxidant stress.
A-190
Hepatic organ protection by isoflurane is mediated by heme oxygenase-1 induction
Department of Anaesthesiology, University Hospital, Freiburg, Germany

Background and Goal of Study: The heme oxygenase (HO) enzyme is responsible for the maintenance of liver perfusion and hepatocellular integrity especially under pathological conditions (1). We have previously shown that isoflurane (ISO) leads to an expression of the inducible isoform of HO (HO-1) in the liver and thus improves hepatic blood flow (2,3). It was the objective of this study to characterize the influence of ISO induced HO-1 expression on hepatocellular integrity after partial ischemia/reperfusion (IR) in the rat.

Material and Methods: After institutional approval, rats (200−300 g) were randomly assigned to four groups: (1) sham controls; (2) IR + vehicle; (3) IR + cobalt protoporphyrin IX (COPp, 5 mg/kg; HO-1 inducer); (4) IR + COPp + tin protoporphyrin IX (SnPP, 50 μmol/kg; HO-inhibitor). Ischemia was induced by clipping the pancreas supplying arteries for 1 h. Functional capillary density (FCD) was measured by intravital epifluorescence microscopy after 2 hrs of reperfusion. Expression of HO-1 mRNA, HO-1 protein and HO activity were assessed by northern blot, western blot and activity assay. Statistical analysis was performed with ANOVA followed by Student-Newman–Keuls tests. Data are expressed as mean ± SD. Differences were considered significant when p < 0.05.

Results: CoPP treatment induced pancreatic HO-1 mRNA and protein levels and increased HO enzyme activity, while SnPP decreased HO activity to baseline levels. Comparison of FCD showed a significant decrease in IR treated animals (154 ± 25 cm²/cm²) as compared to control (267 ± 25 cm²/cm²). Preinduction of HO-1 with CoPP increased FCD after IR to control values (257 ± 25 cm²/cm²). HO activity inhibition of CoPP treated animals decreased FCD significantly (217 ± 26 cm²/cm²) as compared to sham controls and CoPP treated animals.

Conclusion: Preinduction of HO-1 improves pancreatic microcirculation after normothermic IR. Given this improvement, we hypothesize that HO-1 could be of clinical relevance in postischemic pancreatitis by decreasing acute IR during the early onset of reperfusion.

References:

A-191
Selective cerebral low-flow perfusion versus deep hypothermic circulatory arrest: effects on evoked potentials in piglets
C. Leuthold, M. Messner, T. Palmers, R. Cesnjevar, J. Schüttler
Department of Anaesthesiology, University of Erlangen Nuremberg, Erlangen, Germany

Background and Goal of Study: Cardiac surgery is often done in deep hypothermic circulatory arrest. Selective cerebral low-flow perfusion could help to reduce neurological complications (1). Somatosensory evoked potentials (SEP) can monitor neurologic integrity and give us prognostic insights (2). In this study the effect of low flow perfusion on SEP after reperfusion was examined.

Materials and Methods: On approval of local authorities, general anaesthesia, extracorporeal circulation (ECC) and deep hypothermia were established in piglets. 15 subjects were assigned to either “LoFlo” (60 min circulatory arrest, n = 8) or “LoFiO” protocol (60 min perfusion of the t. brachiocephalicus with 10% of the baseline cardiac output, n = 7). After reperfusion and rewarming the ECC was stopped at a core temperature of 36°C.

After induction of general anaesthesia SEP were generated and recorded by stimulation of the N. medianus until 120 minutes after cessation of ECC (Nicolet Viking IV). The recordings were evaluated visually. The frequency of return of cortical SEP was the primary endpoint. For statistical evaluation Fisher’s exact test was used.

Results and Discussions: In animals cortical potentials disappeared during cooling by ECC (a cortical potential could be no longer percepted visually). In all LoFiO subjects there has been no return of cortical SEP activity. In contrast to that, cortical SEP returned in 5 of 7 LoFiO animals. This difference is significant (p = 0.004).

Conclusions: As far as detectable by SEP, the return of neural functionality already within 120 minutes of reperfusion indicates that using low flow perfusion provides a quicker neurologic recovery in cardiac surgery.
A-192
Optimizing cardiac output by fluid loading: effects on liver function and splanchnic microcirculation
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Introduction: Hypovolemia may be associated with hepato-splanchnic hyperperfusion which is of major prognostic relevance (1). In general, optimi-
zizing cardiac preload to increase cardiac output is a primary clinical goal. We tested whether increasing cardiac output by optimizing intravascular fluid status leads to an improved regional, i.e. hepato-splanchnic, blood flow and function.

Methods: After approval by our Ethics Committee we post-operatively studied 12 patients (mean age 66 ± 13 years) with elective coronary artery bypass grafting who underwent extended hemodynamic monitoring by a pulmonary artery for clinical indication. Microcirculation within the splanchnic area was assessed by gastric tonometry, liver blood flow and function non-invasively by transcutaneous measurement of ICG-PDR. All patients were considered hypovolemic and received hemodynamic optimization by infusion of hydroxyethylstarch (130/0.4). Global and regional parameters were measured at baseline and one hour after optimization. All patients were on pressure-controlled mechanical ventilation and respirator settings remained unchanged throughout the study. Data are mean ± SD. A p < 0.05 was con-
sidered significant.

Results: Overall, 630 ± 130 ml of hydroxyethylstarch were administered. Cardiac index and stroke volume index increased significantly after fluid admin-
istration, in average from 2.8 ± 0.7 to 3.6 ± 0.6 l/min/m² and from 30 ± 7 to 38 ± 8 l/min/m², respectively. Central venous and left atrial pressure signifi-
cantly increased from 6 ± 2 to 12 ± 2 and from 5 ± 3 to 11 ± 3 mmHg, respectively. However, ICG-PDR and PCO₂-gap (difference between gastric mucosal and end-tidal CO₂-tension) did not change significantly, i.e. from 21.2 ± 5.6 to 21.6 ± 6.5 mmHg and from 0.9 ± 0.5 to 1.0 ± 0.7 kPa.

Conclusion: Optimizing cardiac output by fluid loading per se is not associ-
ated with a significant change in ICG-PDR or gastric mucosal PCO₂. However, since ICG-PDR increased in all patients with a value <18%/min, particularly patients with a low ICG-PDR may benefit. Further studies are required to test this hypothesis.

Reference:

A-193
Effect of a intravenous infusion of lidocaine on the stress and metabolic responses after laparoscopic colectomy
S. Bianca, A. Kaba, S. Laurent, B. Detroz, M. Lamy, J. Joris
Department of Anesthésie-Réanimation, Centre Hospitalier Universitaire de Liége, Liége, Belgium

Background and Goals: Intravenous (iv) lidocaine (LIDO) is analgesic and anti-inflammatory.1 When used in an acute rehabilitation protocol for laparo-
scopic colectomy (LAPCOL), iv LIDO reduces postop pain, speeds the return of bowel function and allows for a reduction in hospital stay.2 We investigated the effects of iv LIDO on the stress and metabolic responses after LAPCOL.

Materials and Methods: After approval of our institution Ethics Committee, 30 patients scheduled for LAPCOL gave their consent to be included in this randomised double-blind placebo-controlled study. Patients were allocated in two groups: iv LIDO (bolus − 1.5 mg/kg, intraop infusion 2 mg/kg/h, then postop infusion of 1.33 mg/kg/h for 24 h) or saline. Anesthesia (keoflurane in O2/air 80%) and postop analgesia (propacetamol, ketorolac, and PCA opi-
oid) were standardised. All patients were included in the same acute postop rehabilitation protocol.2,3 Postop iv infusion (Glucose 10% 80 ml/h) was stopped 24 h after surgery if oral intake was tolerated. Cortisol and catt-
eolograma were measured intraoperatively, during the first and second postop days. Plasma concentrations of glucose, cortisol, catecholamines, C-reactive protein, and leukocytes counts were also measured 2 h, 6 h, 24 h and 48 h postoperatively. Data were analysed using ANOVA or Students’ t test; P < 0.05 = statistical significance.

Results: Patient data were similar in the two groups. No significant differ-
ences between the two groups were observed with regard to intra and postop release of stress hormones. Concentrations of glucose, C-reactive protein, and leukocytes counts were also similar in both groups.

Conclusions: The beneficial effects of iv LIDO after LAPCOL2 is not medi-
ated by, or not associated with a reduction of the stress and metabolic responses.

References:
1 Hollmann M. et al., Anesthesiology 2000;93:858–75.
PMP (AS of 5.3 ± 2.1 mm²) was eliminated by inhibition of VEGF, bFGF, and PDGF (AS of 0.7 ± 0.5 mm², 1.7 ± 1.5 mm², and 2.4 ± 1.2 mm², respectively, p < 0.02). In the in vivo model of chronic myocardial ischemia used, ligation of the left coronary artery induced a decrease in the number of functional capillaries in ischemic myocardium from 157 ± 42 to 34 ± 21.5 (mean ± SD) capillaries per view field (p < 0.001). However, the amount of functional capillaries increased significantly after injection of PMP into the myocardium (to 97 ± 27; p < 0.001 vs. ischemia without PMP).

Conclusion(s): PMP possesses a strong pro-angiogenic potential and may promote re-vascularization of the ischemic myocardium.

Reference:

A-196
Isocapnic hyperoxia impairs endogenous fibrinolysis in healthy men
A. Thomson, D. Webb, S. Maxwell
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Background and Goal of Study: Fibrinolysis is impaired in acute atherothrombotic disease. Because oxygen tension affects fibrinolysis in animals2, we studied the effects of hypoxia and hyperoxia on fibrinolysis in humans.

Materials and Methods: We carried out a 3 way randomised, cross-over study. On separate visits, healthy volunteers breathed hyperoxic (FIO2 target 0.85), hypoxic (Sao2 target 80%), and normoxic (air) gas mixtures from a tight-fitting face mask. End-tidal CO2 was held constant throughout the study. Substances P (2, 4, and 8 pmol/min) was infused into the non-dominant brachial artery for 10 minutes at each dose to cause endothelium-dependent vasodilatation and release of tissue plasminogen activator (tPA). Forearm blood flow (FBF) was measured by venous occlusion plethysmography at 10 min intervals, and the data analysed using Chart™ software. Venous blood was sampled from both arms at the end of each infusion and analysed for tPA and plasminogen activator inhibitor 1 (PAI-1) antigen using ELISA. Net tPA release was calculated from the product of infused arm plasma flow and the difference in tPA between arms. Data were examined by single factor ANOVA and two factor ANOVA with repeated measures.

Results and Discussion: We studied 8 men (aged 38 (13), 19–53 (mean, SD, range). SP caused dose-dependent release of tPA that was not affected by inspired O2 tension. PAI-1 levels were significantly greater during hyperoxia than hypoxia (p = 0.05) and were not affected by SP.

A-197
Alpha-2B adrenoceptor polymorphism: effects on peripheral vasoconstriction in healthy volunteers
C. Stapelfeldt, P. Talke, E. Lobo, R. Brown, M. Scheinin, A. Snipr
Department of Anaesthesiology and Intensive Care Medicine, University of Schleswig-Holstein, Campus Kiel, Kiel, Germany

Background and Goals of the Study: The alpha-2B adrenoceptor (AR) is the vasoconstrictive AR subtype in mouse1. Human alpha-2B AR deletion (D) allele has been associated with loss of short term agonist-promoted receptor desensitization, which may lead to increased vasoconstriction upon alpha-2B AR activation2. The goal of this study was to test the hypothesis that alpha-2B AR activation will induce enhanced vasoconstriction in carriers of the DD genotype, compared to carriers of the II genotype.

Material and Methods: We administered increasing doses of the alpha-2 agonist dexmedetomidine (targeting plasma concentrations of 0.15, 0.3, 0.6, and 1.2 nmol/ml) to 16 healthy young volunteers (alpha-2B DD genotype: n = 8, II genotype: n = 8). In all subjects, sympathetic effects of the drug were attenuated by general anaesthesia. Measurements included finger blood volume (an indicator of vasoconstriction) detected by photoplethysmographic determination of light transmitted through a fingertip, finger blood flow detected by venous occlusion plethysmography and hemodynamic variables.

Results and Discussion: All concentrations of dexmedetomidine increased light transmitted through a fingertip (vasoconstriction) as well as systolic blood pressure and decreased heart rate in both groups (p < 0.001 for all). Dexmedetomidine reduced finger arterial inflow only in the DD group (p < 0.001). Dexmedetomidine had no effect on finger venous outflow or venous capacitance. There were no significant differences between the II and DD groups in any of the variables.

Conclusions: The results of this study confirm the alpha-2 agonist induced vasoconstriction and hemodynamic effects in peripheral vasculature. However, the results do not support our hypothesis that this alpha-2B AR polymorphism has an effect on peripheral vasoconstriction in humans.

References:

Acknowledgements: We thank the subjects for volunteering their time.

A-198
Effects of nitroprusside and esmolol-induced controlled hypotension on hepatic perfusion and oxygenation in healthy pigs
M. Janda, T. Iber, C. Mutz, J. Roesser, O. Simanski, R. Hofmockel
Department of Anaesthesiology and Critical Care Medicine, University of Rostock, Rostock, Germany

Background and Goal of study: The aim of this animal study was to compare the influence of controlled hypotension (CH) induced by sodium nitroprusside (SNP) or esmolol (ES) on hepatic perfusion and oxygenation. Materials and Methods (1): After ethical approval 17 anaesthetized and ventilated pigs were investigated. Blood flow (BF) was measured in the hepatic artery and portal vein. Arterial and venous blood-gases (femoral and pulmonary artery; portal and hepatic vein) were analysed. CH was maintained at a level of 40 mmHg (MAP) via a closed-loop system. By means of randomisation animals were divided into two groups (ES; SNP).

Baseline values (t0) before and 15 (t1) and 30 (t2) min after starting CH were analysed.

Results:

<table>
<thead>
<tr>
<th></th>
<th>ES (n = 8)</th>
<th>SNP (n = 9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>t0</td>
<td>t1</td>
<td>t2</td>
</tr>
<tr>
<td>Cardiac</td>
<td>139</td>
<td>140*</td>
</tr>
<tr>
<td></td>
<td>(118–150)</td>
<td>(138–150)</td>
</tr>
<tr>
<td>(mL·min⁻¹·kg⁻¹)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BF A. hep.</td>
<td>5.4</td>
<td>6.0*</td>
</tr>
<tr>
<td>(mL·min⁻¹·kg⁻¹)</td>
<td>(4.0–7.0)</td>
<td>(4.0–7.0)</td>
</tr>
<tr>
<td></td>
<td>(0.5–2.4)</td>
<td>(0.5–2.4)</td>
</tr>
<tr>
<td>BF V. portae</td>
<td>27.0</td>
<td>25.0*</td>
</tr>
<tr>
<td>(mL·min⁻¹·kg⁻¹)</td>
<td>(18–30)</td>
<td>(18–30)</td>
</tr>
<tr>
<td></td>
<td>(13–21)</td>
<td>(13–21)</td>
</tr>
<tr>
<td>Hepatic DO₂</td>
<td>93</td>
<td>92*</td>
</tr>
<tr>
<td>(mL·min⁻¹·kg⁻¹)</td>
<td>(85–102)</td>
<td>(85–102)</td>
</tr>
<tr>
<td></td>
<td>(68–112)</td>
<td>(68–112)</td>
</tr>
<tr>
<td>Hepatic VO₂</td>
<td>29</td>
<td>24*</td>
</tr>
<tr>
<td>(mL·min⁻¹·kg⁻¹)</td>
<td>(24–30)</td>
<td>(24–30)</td>
</tr>
</tbody>
</table>

Conclusions: With regard to splanchic oxygenation, SNP is superior to ES in inducing CH since hepatic arterial and portal venous blood flow as well as DO₂ are well maintained. Furthermore, ES may cause a delivery-dependency of oxygen-uptake in the liver.

Reference:
A-199
Activated C protein and endotoxic shock: endothelial effects
M.E. Costecalde, E. Wiel, D. Corseaux, B. Jude, R. Bordet, B. Vallet
Department of Clinique d’Anesthésie Réanimation, C.H.U. Lille-Hôpital Claude Huriez, Lille Cedex, France
Background: Activated protein C (aPC) reduces mortality from severe sepsis. Its mechanism of action remains however unspecifed. We studied the effects of human recombinant activated CP (aCP) in an E.coli lipopolysaccharide (LPS)-induced shock model characterized by delayed endothelial dysfunction and monocytocyte tissue factor (mTF) expression.

Materials and Methods: 4 groups of rabbits were studied. In 2 groups, endotoxic shock was induced by an intravenous (i.v.) bolus of LPS (0.5 mg/kg); one group received an iv aCP injection 1 hour after LPS, the other received saline. The last 2 groups, received only saline iv injection, with or without injection of aCP in the same conditions. We assessed in vitro vascular reactivity on abdominal aortic rings, in particular phenylephrine (PE) sensitivity, and mTF expression five days (DS) after LPS injection. Immunohistochemistry (CD31) was performed at D5 to assess damaged endothelial vascular reactivity on abdominal aortic rings, in particular phenylephrine (PE) sensitivity, and mTF expression five days (DS) after LPS injection. Immunohistochemistry (CD31) was performed at D5 to assess damaged endothelial structure.

Conclusion: aPC was not able to decrease the mortality rate of endotoxinic rabbits (1 death/6 animals in LPS group vs. 0 death/6 animals in aPC group). aPC did not decrease the mortality rate of endotoxic rabbits (1 death/6 animals in LPS group vs. 0 death/6 animals in aPC group).

A-200
In-vivo videomicroscopy of mesenteric postcapillary venules after cardiac arrest in rats
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Background and Goal of Study: Recent data demonstrate, that the ischemia-reperfusion syndrome after whole body ischemia following cardiac arrest (CA) shows similar pathological findings like septic patients (1). As the microcirculation plays a central role in the pathogenesis in sepsis, we therefore evaluated the combination of two established models of (a) experimental CA (2) and (b) in-vivo microscopy of postcapillary mesenteric venules (3) in rats to investigate the leukocyte endothelial interaction (LE), plasma extravasation (PE), and wall shear rate (WSR) in postcapillary mesenteric venules.

Materials and Methods: After approval of the animal care committee, male wistar rats were subjected to 6 min CA (2). At 30 min after successful cardio-pulmonary resuscitation, the rats were reanaesthetized and a laparotomy for fluorescent-labeled erythrocytes. Data were acquired at baseline, 60 and 120 min. A sham group served as control.

Results and Discussions: Compared to controls, (CO) the WSR was strongly reduced at baseline and recovered at 120 min to normal values. The rollers and stickers were increased at baseline and decreased to normal values at 120 min. At baseline the PE was 4 fold stronger and continued to be 3-4 fold stronger at 120 min as compared to the CO. These data indicate that animals surviving CA show signs of microcirculatory impairment such as LE and PE. The increase of PE is a typical sign of endotoxaemia, whereas the early normalization of the WSR and LE might indicate active repair mechanisms of the animals.

Conclusions: To our knowledge this is the first study showing a link between ischemia reperfusion injury after CA and the pathogenesis of sepsis in such a model. If these results can be validated in further studies, this might open new therapeutic strategies in the treatment of patients surviving CA.

References:
1. Feingold K. Am J Physiol Endocrinol Metab. 2004; 286: E201

A-201
Myofilament calcium resensitization accounts for the protective effect of fenofibrate on septic heart in rats
H. Brisson, E. Jozefowicz, S. Rozenberg, R. Bordet, B. Vallet, B. Tavernier
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Background and Goal of Study: The nuclear factor PPARα regulates genes involved in metabolic, inflammatory, and oxidative responses to stress. We recently showed that a pretreatment with fenofibrate (Feno, a PPARα activator) prevented the septic myocardial dysfunction in rats. Our aim was to identify the cellular mechanisms involved in this protective effect.

Materials and Methods: adult male rats received standard chow diet or food containing Feno for 14 days Myofilament Ca2+ sensitivity (skinned fibres method), the inflammatory response (NOx) and the oxidative stress (TBARS) were measured in myocardium 12 hours after LPS (5 mg/kg) or saline (SP) i.v. injection. 4 groups were thus studied: SP, Feno + SP, LPS and Feno + LPS. 4 were thus studied: SP, Feno + SP, LPS and Feno + LPS. The results (mean ± SEM) were compared by ANOVA.

Results and Discussions: A decreased myofilament Ca2+ sensitivity, as attested by a reduction in pCa50 (the Ca2+ concentration corresponding to half-maximal force, with pCa = – log10[Ca2+]) was found in the LPS skinned fibres group. This effect was prevented by Feno (figure).

The NOx and TBARS measurements were similar in LPS and Feno-LPS groups.

Conclusion(s): Fenofibrate pretreatment appears to prevent the septic myocardial dysfunction by preventing Ca2+ desensitization of myofilaments. This effect was not associated with a reduction of the tissue inflammatory response or oxidative stress. Our results are consistent with recent findings (1,2) suggesting that this protective effect may be due to an increase in fatty acid metabolism and oxidation in heart.

References:

A-202
When do we start Glucose-Insulin-Potassium – Comparison of two regimens in patients with severe left ventricular dysfunction undergoing coronary artery bypass grafting
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Department of Cardiac Anaesthesiology and Critical Care Medicine, Institute of Cardiovascular Diseases, Madras Medical, Chennai, India

Background and Goal of Study: Glucose is a preferential fuel in first hour of coronary artery bypass grafting (CABG) for functional recovery of heart with reduced cardiac function preoperatively. Glucose Insulin Potassium (GIK) reduces ischaemic myocardial damage after coronary revascularisation. The goal of the study is to evaluate the efficacy of two perioperative GIK infusion regimens in patients with severe Left ventricular dysfunction undergoing CABG.

Materials and Methods: A prospective, randomized study on 30 patients undergoing on-pump CABG with left ventricle (LV) ejection fraction less than 35% was conducted. Glucose (95 ml of 25% dextrose) and potassium (5 ml i.e. 10 meq) at rate of 0.5 ml/kg with separate insulin infusion (0.05 UI/kg/hr) was started 12 hrs preoperatively, stopped at induction, restarted depending on groups assigned and continued 48 hrs postoperatively. In Group 1 (n = 15), GIK was started on aortic cross clamp (ACC) release and in Group 2 (n = 15) after shifting to ICU. Patients undergoing combined procedures and those with documented renal failure, hepatic insufficiency, hyperkalaemia were excluded from the study.

Results: Group 1 showed higher postoperative cardiac indices at 12 and 48 hours compared to Group 2 (3.14 and 3.57 l/min/m2 vs 2.6 and 3.01 l/min/m2, P = 0.05). Left ventricular work index (37.3 vs 31.5–g/m2,
P = 0.04) improved in Group 1. Group 1 showed lower inotrope scores (12.3 ± 2.2 vs 28.2 ± 3.6, P = 0.04), decreased incidence of arrhythmias (6.6% vs 56.6%, P = 0.01), and decreased IABP usage (14.3% vs 33.3%, P = 0.03). Duration of ventilation (mean 38.8 vs 42.8 hrs, P = 0.9) and length of ICU stay (mean 3.4 vs 5.02 days, P = 0.08) were statistically not significant but clinically significant. Serum Troponin-I (0.57 ± 0.7 vs 0.62 ± 0.7, P = 0.01) and CPK-MB (0.5 ± 0.3 vs 3.8 ± 7.1, P = 0.04) levels were statistically not significant in both groups. There was no mortality in either group.

**Conclusion:** Substrate enhancement with GIK at an appropriate time i.e., after ACC release, improved myocardial performance and resulted in faster recovery after CABG in patients with severe LV dysfunction.

**A-203**

**Beta-endorphin plasma levels during regional myocardial ischaemia and myocardial stunning in chronically instrumented conscious dogs**


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**Background and Goal of Study:** In a previous study we have shown that the opioid receptor antagonist naloxone improves recovery from myocardial stunning in chronically instrumented conscious dogs (1). Beta-endorphin (β-endorphin) release is a component of the neuroendocrine activation associated with myocardial ischemia (2). The aims of the present study were (a) to determine whether myocardial stunning induces β-endorphin release and (b) to characterize the profile of β-endorphin plasma levels during the time course of myocardial stunning.

**Materials and Methods:** This study was approved by the local Animal Care Committee. Ten dogs were chronically instrumented for measurement of heart rate, left atrial and left ventricular pressure, coronary blood-flow velocity and myocardial wall-thickening fraction (WTF). Occluder around the left anterior descending artery (LAD) allowed the induction of a reversible 10 min LAD-ischemia. Experiments were performed after a postoperative recovery period of 12 days. Peripheral β-endorphin levels were measured in duplicate by radioimmunoassay under baseline conditions (BL), during ischemia and 1, 5, 15 and 30 min and 1, 3, 6, 12 and 24 h after the beginning of reperfusion. The haemodynamic parameters were recorded at the same points of time. Data were analysed using Wilcoxon matched pair rank test. Statistical differences were considered significant at p < 0.05. Data are presented as mean ± SD.

**Results:** β-endorphin [pmol·l⁻¹] BL plasma concentrations were 5.95 ± 0.63 (mean ± SE) β-endorphin levels increased significantly after induction of ischemia with a peak value of 13.11 ± 1.64. They remained elevated after the first minute of reperfusion (9.34 ± 1.21) and returned to BL levels after 5 min. Regional ischemia led to a reduction of WTF to negative values (−39 ± 14% of BL). Pre-ischemic WTF values were reached after 24 h of reperfusion.

**Conclusions:** Peripheral β-endorphin plasma levels are increased during regional myocardial ischemia and early reperfusion in chronically instrumented conscious dogs. With regard to the findings of our previous study (1) these results indicate that the endogenous opioid system has an important pathophysiological role in myocardial stunning.

**References:**


**A-204**

**Mu opioid receptor antagonist reduces splanchnic perfusion in chronically instrumented conscious dogs**


Department of Anaesthesiology and Intensive Care, University Hospital of Muenster, Muenster, Germany

**Background and Goal of Study:** In a previous study we demonstrated that the non-selective opioid receptor antagonist naloxone improves splanchnic perfusion in chronically instrumented conscious dogs (1). The present study investigates the effects of a selective μ-opioid receptor antagonist with naloxonazine (NLX) on the regional blood flow distribution of intraabdominal organs.

**Materials and Methods:** The study was approved by the local Animal Care Committee. Ten healthy dogs were chronically instrumented for measurement of heart rate (HR), left atrial and aortic pressure (MAP), Cardiac output (CO) was assessed non-invasively by transthoracic Doppler echocardiography. The regional blood flow (RBF) was determined with fluorescent microspheres. Experiments were performed after a postoperative recovery period of 12 days. In all animals, RBF and CO were assessed (a) before application of the selective μ-opioid receptor antagonist (Baseline) and (b) 24 hours after pretreatment with NLX (10 mg/kg i.v. over 30 min). Tissue samples were taken in triplicate in a systematic way. Data were analysed using Wilcoxon matched pair rank test. Statistical differences were considered significant at p < 0.05. Data are presented as mean ± SD.

**Results and Discussions:** In comparison to baseline, NLX resulted in a significant reduction in arterial RBF (ml/min/g) of distal jejunum (0.37 ± 0.04 vs. 0.24 ± 0.03), proximal ileum (0.73 ± 0.03 vs. 0.37 ± 0.05), proximal colon (0.75 ± 0.06 vs. 0.4 ± 0.04), distal colon (0.83 ± 0.08 vs. 0.48 ± 0.06), liver (0.16 ± 0.02 vs. 0.22 ± 0.03), renal cortex (5.33 ± 0.48 vs. 3.29 ± 0.29), renal medulla (0.38 ± 0.05 vs. 0.22 ± 0.03) and skeletal muscles (0.38 ± 0.04 vs. 0.14 ± 0.02). The RBF of gastric corpus (1.29 ± 0.08 vs. 1.42 ± 0.06), gastric antrum (0.87 ± 0.08 vs. 0.73 ± 0.09), duodenum (0.83 ± 0.05 vs. 0.69 ± 0.03), proximal ileum (0.28 ± 0.04 vs. 0.36 ± 0.05), distal ileum (0.52 ± 0.04 vs. 0.42 ± 0.06), spleen (2.44 ± 0.27 vs. 2.46 ± 0.23) and pancreas (2.86 ± 0.15 vs. 2.79 ± 0.23) was not significantly changed. CO (3.24 ± 0.35 vs. 2.63 ± 0.27 l/min), HR (90 ± 8 vs. 92 ± 11 bpm) and MAP (98 ± 8 vs. 92 ± 6 mmHg) remained unchanged.

**Conclusion:** The selective μ-opioid receptor antagonist NLX deteriorates splanchnic perfusion in chronically instrumented conscious and normovolemic dogs. This effect is independent of the CO.

**Reference:**


**A-205**

**Influence of a TNF-beta gene polymorphism on perioperative renal dysfunction in cardiac surgery with cardiopulmonary bypass**

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**Background and Goal of Study:** Cardiac surgery with cardiopulmonary bypass (CPB) can cause acute renal dysfunction perioperatively, which is associated with an increased mortality. (1) It is also known that genetic polymorphisms influence perioperative outcome. (2) Therefore, the aim of our study was to investigate a possible association between a polymorphism in the TNF-β gene and perioperative renal dysfunction after CPB.

**Materials and Methods:** After approval of the regional ethics committee, 62 patients undergoing elective coronary aortic bypass graft surgery were enrolled consecutively. DNA was isolated from peripheral blood, amplified with PCR and digested with a restriction enzyme. The genotypes were assessed with gel electrophoresis. N-acetyl-glucosaminidase (NAG), fractional sodium excretion (FSE), creatinine clearance (CC) and 1-1-microglobulin (AMG) were measured as markers of tubular and glomerular renal dysfunction at four time points perioperatively: way. Data were analysed using logistic regression. Results and Discussions: TNF-B1/B1 homozygotes had a higher increase of FSE after CPB compared to the other genotypes, returning to their level 24 h postoperatively. Regarding NAG, TNF-B1/B2 heterozygote patients showed a significant rise immediately post-CPB that declined to baseline about one hour later, while the other genotypes had no significant changes. TNF-B1/B1 individuals had the lowest increase of AMG as compared to the other genotypes over the entire post-CPB course. No differences between the genotypes could be detected for CC.

**Conclusion(s):** These results may suggest an association between the TNF-β polymorphism and renal dysfunction after CPB. Our data could possibly result in an improved preoperative risk assessment and prophylaxis of renal complications in cardiac surgery.

**References:**


**A-206**

**Adrenomedullin during renal transplantation**

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Department of Anesthesiology, Nakashibetsu Town Hospital, Nakashibetsu, Japan

**Background and Goal of Study:** Adrenomedullin (ADM) is known to be vasorelaxing and natriuretic peptide. ADM is increased in patients with...
hypertension, heart failure and heart transplantation. It was reported that circulating ADM was increased after renal transplantation (1). We investigated when ADM plasma level elevated during kidney transplantation.

Materials and Methods: We studied 7 ASA 2–3 adult patients (age 24–55) undergoing living-related renal transplantation in Hokkaido University Hospital. We measured ADM concentrations after inducing anesthesia (T0), just before reperfusion (T1), just after reperfusion (T2), 1 hour after reperfusion (T3), and at the end of surgery (T4). Repeated measures ANOVA was used for statistical analysis.

Results: Data (mean ± SD) are shown in Table.

<table>
<thead>
<tr>
<th>ADM (pmol/L)</th>
<th>T0</th>
<th>T1</th>
<th>T2</th>
<th>T3</th>
<th>T4</th>
</tr>
</thead>
<tbody>
<tr>
<td>29.7 ± 8.3</td>
<td>38.6 ± 7.4</td>
<td>43.4 ± 9.5</td>
<td>55.7 ± 19.3*</td>
<td>77.2 ± 26.3**</td>
<td></td>
</tr>
</tbody>
</table>

*p < 0.05 vs T0, **p < 0.05 vs T3.

ADM concentrations increased in the course of surgery. ADM at T3, 4 significantly elevated compared to ADM at T0. In previous report (1), mean concentration of ADM after renal transplantation was 69.1 ± 10.6, and this value is similar to our result at T4 (77.2 ± 26.3).

Conclusions: Our study showed that ADM plasma level elevated from post-reperfusion, especially 1 hour after reperfusion, and continued to increase until the end of surgery. We suggest that circulating ADM increases after reperfusion and is kept at high level after kidney transplantation.


A-207
Predictors of atrial fibrillation following Off-pump CABG
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Background and Goal of Study: Postoperative atrial fibrillation or flutter (AF) is a common complication, with an incidence that is consistently reported to range between 20% and 40% of patients after CABG, with little change over the past 20 yrs. Postoperative AF is associated with increased risk of stroke, and longer hospitalization. The pathophysiology of postoperative AF is uncertain, and its prevention remains suboptimal. Age is the most consistent predictor of AF following on-pump CABG according to the previous reports. Recent study documented that off-pump technique does not reduce the incidence of AF. The aim of present study is to elucidate predictors of AF after off-pump CABG.

Materials and Methods: A total of 265 consecutive patients undergoing off-pump CABG surgery (Age 68 ± 9 yr, m/f = 190:75) between 2001 and 2003 in our institution were enrolled in this prospective observational study. Continuous ECG monitoring were performed at least 72 hr after surgery depending on patients condition. 12-lead ECGs were recorded if arrhythmia was suspected. Thereafter, intermittent ECG assessments were performed.

Results and Discussions: A total of 62 patients (31%) developed AF after off-pump CABG. Stepwise multivariate analysis identified increased age (OR 10.2, CI 1.9–60.4), intraoperative low cardiac output (OR 0.04, CI 0.002–0.5), and decreased intraoperative water balance (OR 0.07, CI 0.005–0.75) as the independent predictor of postoperative atrial fibrillation. No significant differences were found in postoperative AF incidence, and time distribution of AF onset between our present findings concerning off-pump CABG, and previous reports concerning on-pump CABG. Postoperative AF caused the extension of ICU stay in off-pump CABG patients.

Conclusion: Maintenance of cardiac output along with appropriate hydration is necessary to prevent perioperative AF following off-pump CABG. Larger patient numbers, and multi center studies are required to determine the precise risk factors.

A-208
Poor intraoperative blood glucose control is associated with a worsened hospital outcome after cardiac surgery in diabetics
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Department of Anesthesiology, Pitité-Salpêtrière Hospital, Paris, France

Background and Goal of Study: The perioperative glycemic control improves outcome of diabetic patients undergoing cardiac surgery (1). Most of these studies focused on postoperative period. However, severe hyperglycemia during on-pump cardiac surgery in despite insulin therapy has been reported (2). The aim of this study was to determine whether a poor intraoperative glycemic control could be associated with a worsened hospital outcome.

Materials and Methods: After approval by our ethical committee, 200 consecutive diabetic patients undergoing on-pump cardiac surgery were included. The intraoperative insulin therapy was initiated as soon as blood glucose level (BGL) was >180 mg/L according a standardized protocol. A poor intraoperative glycemic control was defined by a four consecutive glucose level (BGL) was >180 mg/L according a standardized protocol. A poor intraoperative glycemic control could be associated with a worsened hospital outcome.

Results and Discussion: A poor intraoperative glycemic control was significantly more frequent in patients suffering from severe postoperative morbidity (37% versus 10%, P < 0.001). The adjusted odd ratio for severe postoperative morbidity among patients with a poor intraoperative glycemic control was 4.4 (95% confidence interval 2.7–6.7). Therefore, we investigated whether poor intraoperative glycemic control is significantly associated with a worsened hospital outcome. Our results suggest that a tight glycemic control should be initiated from intraoperative period in diabetic cardiac surgical patients.


A-209
The erythropoietin receptor is expressed in the human heart and upregulated after cardiac/pulmonary bypass: role of hypoxia and possible mechanism of myocardial protection
Department of Anesthesiology, University Luebeck, Luebeck, Germany

Background and Goal of Study: Erythropoietin (EPO) administration in acute stroke revealed clinically significant neuroprotection. Recently, animal experiments showed superior cardiac function in EPO treated animals subjected to myocardial infarction. While in cell lines and rodent myocardium the EPO receptor had been described, for the adult human myocardium there is no such report to date. Therefore, we investigated adult human cardiac tissue for the presence of the EPO receptor and to identify the cell types expressing the EPO receptor.

Materials and Methods: After approval by the Institutional Review Board, ventricular tissue from the muscular septum obstructing the left ventricular out flow tract (Morrow procedure) or right atrial tissue from the site of the venous canulization was obtained (n = 4 per group). Additional samples were obtained before and after cardio/pulmonary bypass (CPB). Tissue samples were investigated for the EPO receptor and the transcription factor HIF-1alpha by RT-PCR, Western blot and (double) immunohistochemistry.

Results and Discussions: We show for the first time that EPO-R mRNA and protein is indeed expressed in adult human atrial and ventricular tissue. Cardiac EPO receptor positive cells were the cardiomyocytes of atrial and ventricular origin as well as vascular endothelial cells. To investigate if the EPO-receptor was hypoxia/HIF-1alpha regulated, tissue before and after CPB was analyzed. Prior to CPB, HIF-1alpha was strongly upregulated consistent with preexisting myocardial ischemia/hypoxia. After CPB HIF-1alpha was decreased due to the improved perfusion following CABG, and the EPO-receptor was markedly upregulated.

Conclusion(s): EPO-receptor is expressed in the human heart. These findings encourage to investigate the potential of EPO-induced myocardial cytoprotection in humans. The EPO-receptor in the heart appears not to be regulated by HIF-1alpha.

Acknowledgement: Bundesministerium (VF 07/03/65/2004–5, RD/KFW).

A-210
The perioperative renal function in cyanotic versus acyanotic children undergoing open heart surgery under sevofurane anaesthesia
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Background and Goal of Study: There are few data on perioperative renal function in cyanotic children (1). We aimed to investigate the perioperative renal function in cyanotic versus acyanotic children undergoing open heart surgery under sevofurane anaesthesia.

Materials and Methods: After receiving ethical committee approval, 12 acyanotic patients (preoperative oxygen saturation: SaO₂ > 85%) and 12 cyanotic children (SaO₂ < 85%) were included. Sevofurane was given at concentration levels of 2% before cardiopulmonary bypass (CPB) and 1–2% during CPB with BIS monitoring after standard anaesthesia induction. Inorganic fluoride (IF), electrolytes, creatinine (Cr), uric acid nitrogen in serum and urine samples, N-acetyl-β-D-glucosaminidase (NAG) in urine samples were measured before induction (t1), before CPB (t2), during CPB (t3), after CPB (t4), at the end of the operation (t5) and 24 hours postoperatively (t6). T-test and chi-square tests were used for statistical analysis.

Results and Discussion: The levels of serum and urine of inorganic fluoride were higher in the cyanotic group (p < 0.05). There were no differences in the levels of serum and urine IF between the groups, the levels of serum IF at t2, t3, t4, t5 and the levels of urine IF at t3, t4, t5, t6 were higher compared to t1 in the cyanotic group. No differences were found in the levels of serum and urine Cr, uric acid nitrogen and electrolytes and NAG levels between the two groups. Data is given as mean ± SD.

### Acyanotic

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (months)</td>
<td>55.8 ± 36.4</td>
</tr>
<tr>
<td>Sex (F/M)</td>
<td>8/6</td>
</tr>
<tr>
<td>Weight (kg)</td>
<td>16.0 ± 6.7</td>
</tr>
<tr>
<td>Anesthesia time (min)</td>
<td>54 ± 15</td>
</tr>
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</table>

### Cyanotic

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (months)</td>
<td>40.3 ± 23.1</td>
</tr>
<tr>
<td>Sex (F/M)</td>
<td>6/6</td>
</tr>
<tr>
<td>Weight (kg)</td>
<td>14.4 ± 5.7</td>
</tr>
<tr>
<td>Anesthesia time (min)</td>
<td>215 ± 48</td>
</tr>
</tbody>
</table>

Conclusion(s): We concluded that, renal function is affected similarly despite increases the levels of inorganic fluoride, in acyanotic and cyanotic children in sevofurane anaesthesia undergoing open heart surgery.

Reference:

A-211
Low cardiac troponin I elevations predict in hospital mortality after major vascular surgery
Y. Le Manach, G. Godet, M. Bertrand, M.H. Fléron, J.P. Goarin, P. Coriat
Department of Anaesthesia Réanimation, Pitié-Salpêtrière, Paris, France

Background: Cardiac Troponin I (cTnI) is the most reliable cardiac biomarker for the post-operative period. Elevation upper than 1.5 ng/mL usually define myocardial infarction and are known to be associated with increased mortality. The aim of the study was to evaluate association between low cTnI elevations (below 1.5 ng/mL) and in hospital mortality.

### Material and Methods:
All patients scheduled for abdominal aortic surgery from September 1995 to November 2002 were included. cTnI measurements were done for each patient at recovery and on POD 1 to 3, and in case of cardiac complication. The levels of serum uric acid were retained in this study. Patients with major surgical complications were excluded. Multivariate analysis was performed to determine variables associated with in hospital mortality.

### Results and Discussion:
Global observed mortality is 4.2%. cTnI level, Age and Lee Risk Score were independent predictors of in hospital mortality. Low cTnI elevations were associated with increased in hospital mortality:

<table>
<thead>
<tr>
<th>Variable</th>
<th>OR (95%, CI)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post Operative cTnI Peak</td>
<td>8.1</td>
<td>2.9; 22.8</td>
</tr>
<tr>
<td>Abnormal Below 1.5ng/mL</td>
<td>3.9</td>
<td>1.8; 8.4</td>
</tr>
<tr>
<td>Age (year increase)</td>
<td>1.0</td>
<td>1.03; 1.14</td>
</tr>
<tr>
<td>Lee Risk Score</td>
<td>1.0 (by 1 point increase)</td>
<td>2.7</td>
</tr>
</tbody>
</table>

Conclusion(s): Each cTnI elevation was associated with increased mortality. Abnormal value of this biomarker, even low, should be considered as important postoperative adverse events, and should require adapted treatment.

Reference:

A-212
Prevalence of genetic mutations and incidence of VTE in caucasian pregnant women
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Background and Goal of Study: Thromboembolic events are leading cause of maternal morbidity and mortality. The risk of venous thrombosis in women increases 5-fold during pregnancy: with any additional risk factors, this frequency increases further. Finally, women with a history of thromboembolic events are at an especially increased risk of recurrence when they become pregnant.

### Materials and Methods:
From Jan 2002 to Jan 2003 we admitted to our department 2200 pregnant women. We screened for thrombophilic genetic mutations 660 women: 40% was non 0 blood type, 33% BMI >27, 29% age >35 years.

- The patients underwent: Ultrasonography Duplex Scan; Colour Doppler Cava Vein; TC Spiral Scan Cava Vein, Iliac Veins, Femoral Veins, blood assays for S Protein, C Protein, ATIII, DDIMER cut-off line >500, thrombophilic agents (Factor II, Factor V Leiden, MTHFR).

### Results and Discussions:
Of 378 non mutated women (2.6%) (9 women) developed VTE – of 222 women were affected of genetic mutations for thrombophilia 23% (55 women) developed VTE. (chi-square 54.97; p < 0.0001).

- Of the 3 women who developed proximal-high (femoral and iliac veins) VTE 1 was affected of Factor V Leiden homozgyosis and MTHFR homozgyosis, 2 were affected Factor V Leiden homozgyosis and MTHFR heterozygosis. These women were treated with positioning vein caval filter for the presence of flutterant thrombus. Other 52 women were developed proximal medium VTE (popliteal veins) were treated with conventional methods using LMWH and elastic stocks.

Conclusion(s): Thromboembolic venous disease is multifactorial and increases in percentage in pregnant women over 35 years old with thrombophilic genetic mutations and also in overweight women during pregnancy.

### References:

A-213
Oculocardiac reflex and ETCo2 level during eye surgery
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Background and Goal of the Study: We noted that the severity of an oculocardiac reflex may be influenced by the expired carbon dioxide (CO2) concentration. The diving reflex is increased by high CO2 concentrations. We determined if high or low expired CO2 affected the severity of the oculocardiac reflex.

### Materials and Methods:
With approval by our Department Committee, 30 pediatric patients having ophthalmologic survey were studied. A standard inhalation induction and maintenance of anesthesia with Halothane was performed. The patients were intubated and an intravenous catheter placed. No patients received any anticholinergic. The patients were then randomized to beginning with either a high (50 mmHg) or low (25 mmHg) expiratory CO2 concentration as measured by Nardomed III Multispec spectrometer. The patients respirations were controlled. A standardized 200 gm traction was placed on an extraocular muscle while the electrocardiogram (ECG) was recorded. The opposite (low or high) expired CO2 concentration was then obtained by controlled ventilation. The ECG was again recorded during a standardized 200 gm on an extraocular muscle. The location of the extraocular muscle...
The mean age of the patients studied was 7.7 ± 7.2 years. The mean low and high expired CO2 concentrations were 28.3 ± 4.1 and 48.8 ± 6.9 mmHg, respectively. Expiratory Halothane concentrations during the two episodes of testing were 1.4 ± 0.3 and 1.3 ± 0.4 (P = 0.1). There were three (10% of patients) episodes of severe bradycardia with extracranial traction during the high expired CO2 concentration and only one (3.3% of patients) during the low. The mean change in heart rate with extracranial traction during the period of high and low expired CO2 were 17.7 ± 18.2% and 12.1 ± 14.8%, respectively (P = 0.06)². There were more clinically significant bradycardia episodes with high expired CO2 concentration that during low (10% vs. 3.3%) and there was a trend for a greater drop in mean heart rate with high CO2.

Conclusion: It may be beneficial to avoid hypercardia during ocular surgery for not having severe ocularcardiac reflex².

References:

A-214
Troponin-T for detecting myocardial ischemia in patients undergoing different anesthesia techniques for transurethral resection
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Background and Goal of Study: It is well known that cardiac complications are more frequently encountered in elderly patient population after transurethral resection of prostate (TUR-P) (1,2). The aim of the study was to assess the early recognition of myocardial injury in patients, scheduled for TUR operations under general, spinal or epidural anesthesia.

Methods: ASA I-II, 45 cases randomly divided into 3 groups to receive either general anesthesia, spinal anesthesia or epidural anesthesia. Preoperative ECG, Creatinin kinase muscle and brain (CK-MB), creatinin phosphokinaze (CPK) and Troponin-T (TnT) levels were evaluated in all patients. Intraoperative hemodynamic parameters were recorded at 5., 10., 15., 20., 30., 40., and 60. minutes. Laboratory tests were repeated in the postoperative period.

Results: CK-MB, CPK values of all cases have increased in the postoperative period. TnT-T tests were positive in 9 cases of the general anesthesia group, in 9 of the spinal anesthesia and in only one case of the epidural anesthesia group.

Conclusion: We conclude that epidural anesthesia may be superior than general or spinal anesthesia in TUR-P operations when myocardial protective effect is considered.

References:

A-215
Comparison the effects of inhalation anaesthetics and TIVA on post-perfusion injury in cardiopulmonary bypass
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Background and Goal of Study: In our study, we searched the effects of inhalation anesthesia and TIVA on ischemia-reperfusion injury during cardiopulmonary bypass surgery (CPBPS). We aimed to compare the effects of two different anaesthetic methods on myocardial protection.

Material and Methods: The study were performed in 59 patients under cardiopulmonary bypass surgery. The patients were divided into three groups randomly. There were given desflurane in group I (n = 20), sevoflurane in group II (n = 20) and TIVA in group III (n = 19) patients. The patients were prepared for operation with standard method and were 5 mg diazepam premedicated preoperatively. There were given to patients 2 mg/kg ropofol, 10-25 mcg/kg fentanyl for induction. Patients were intubated after 0.5 mg/kg thiopentone and succinyl bromide injection. There were given to group I 4–mcg/kg 1-h fentanyl by infusion and 1–3 MAC sevoflurane, to group II 1–4 mcg/kg 1-h fentanyl by infusion and 1–1.5 MAC sevoflurane and to group III 0.3–12 mcg/kg 1 min-1 fentanyl and 0.07 mg kg-1 h-1 midazolam by iv infusion for maintenance of anaesthesia. During the CPB perfusion pressure was hold same level (60–80 mmHg) in all patients. Patients were operated under moderate hypothermic (28–32°C) condition. Arterial blood samples were taken in preoperatif period (S0), and 2nd hours (S1), 24th hours (S2) in post-pump period. Serum AST, ALT, CK-MB, cTnI and proinflamatory cytokine levels (IL-6, IL-8 and TNF-α) were analysed in blood samples.

Results and Discussion: Comparison CK-MB, cTnI, ALT, AST, IL-6, IL-8 and TNF-α levels increased in all groups at 2nd and 24th hour after CPB (p < 0.001).

Conclusion: There was no difference between inhalation anaesthesia and TIVA, above myocardial protective and pharmacological preconditioning effects in CPBPS (1).

Reference:

A-216
Comparison between endocrine stress response and myocardial markers of cardiac surgical patients undergoing a total intravenous anesthesia (TIVA) with propofol and balanced anesthesia with sevoflurane under neurologic monitoring
Department of Anaesthesiology, Hannover Medical School, Hannover, Germany

Background and Goal of Study: We investigated the course of stress response from patient undergoing a total intra-venous anesthesia (TIVA) compared to a balanced anesthesia with Sevoflurane under Neurologic monitoring and its influence on myocardial ischemia parameters after coronary surgeries.

Materials and Methods: Prospectively randomised studies with two groups (A, B) of each 20 patients of ASA risk group III, who were undergoing coronary artery bypass graft surgery (CABG) using extracorporeal circulation (ECC). The study was approved by ethical committee and all patients gave their written consent. Group A balanced anesthesia with Sevoflurane (0.5–2 vol%), Fentanyl and Pancuronium. Group B TIVA with Propofol ca. 3–10mg/Kg/h, Fentanyl and Pancuronium. In both groups anesthesia was induced with propofol. Also during ECC anesthesia was maintained with Propofol in both groups. Concentration of anesthetic agents in all groups was titrated to maintain a Bis index value of 40. Additionally AEP and continuous galvanic skin reflex measurements were carried out. Perioperatively epinephrine, norepinephrine, ADH, ACTH and cortisol were determined at seven particular points of time (T). Moreover, intraoperative hemodynamic parameters were registered as well as CK, CK-MB and troponin T at 3T postoperatively. Statistical evaluation by ANOVA. Level of significance was determined by p < 0.05.

Results and Discussions: Demography, hemodynamic data and neurologic monitoring parameters were comparable between both groups. Significant differences between ADH (µg/ml) T3 34.1 ± 46.8 (A) vs. 8.9 ± 7.0 (B), T5 58.7 ± 48.6 (A) vs. 38.5 ± 56.3 (B); epinephrine (µg/ml) T4 105.8 ± 146.8 (A) vs. 82.9 ± 105.8 (B), T5 307.7 ± 399.2 (A) vs. 66.9 ± 69.4 (B); norepinephrine (µg/ml) T5 3330.7 ± 5685.2 (A) vs. 621.3 ± 475.1 (B); as well as cortisol (µg/dl) T5 19.7 ± 7.9 (A) vs. 14.3 ± 6.6 (B) and T7 17.3 ± 7.2 vs. 12.0 ± 6.4.

Conclusion(s): Under comparable depth of anesthesia a TIVA with propofol, showed a minor course of endocrine stress response in comparison to a balanced anesthesia with sevoflurane. In contrast to other studies, there was no significant difference between the groups concerning postoperative course of CK, CK-MB and troponin-T in coronary surgery patients.

A-217
What's the significance of very low increases of troponin lc levels after vascular surgery? A retrospective study
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Background and Goal of Study: Troponin lc is a highly sensitive marker of cardiac injury including for postoperative myocardial infarction. Troponin lc and outcome were closely associated in acute coronary syndromes, and the same results were observed during the early postoperative period. The primary end-point of this retrospective study was to determine the impact of a very small postoperative increase in troponin lc level to a value between 0.4 to 1.5 mg/ml on long term survival.

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Materials and Methods: We reviewed 1477 operations of vascular surgery from January 2001 to June 2004. 76 patients who had troponin Ic blood levels between 0.4 and 1.5 ng/ml during the first 72 postoperative hours, were matched with 76 patients who underwent the same surgery, and had the same demographic characteristics, but no troponin increase during the 72 first hours after surgery. The mortality and cardiac outcome after a one to three years follow-up period were studied.

Results and Discussions:

<table>
<thead>
<tr>
<th>Case n = 76</th>
<th>Control n = 76</th>
<th>P value</th>
<th>RR (%) (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All major cardiac events</td>
<td>25/76</td>
<td>9/76</td>
<td>0.00312*</td>
</tr>
<tr>
<td>ECG alternation</td>
<td>3/76</td>
<td>3/76</td>
<td>NS</td>
</tr>
<tr>
<td>De novo angina pectoris</td>
<td>10/76</td>
<td>2/76</td>
<td>0.03*</td>
</tr>
<tr>
<td>Myocardial infarction</td>
<td>12/76</td>
<td>4/76</td>
<td>0.06</td>
</tr>
<tr>
<td>Death (all causes)</td>
<td>15/76</td>
<td>6/76</td>
<td>0.032**</td>
</tr>
</tbody>
</table>

*chi square test, **generalized Wilcoxon test.

Conclusion(s): Even small increases of troponin Ic levels were associated with an increased risk of mortality and cardiac events up to three years after vascular surgery.

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Extubate cardiac valve patients in the operating room: high thoracic epidural anesthesia (HTEA) in combination with minimal invasive surgical approach

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Background and Goal of Study: To assess the effectiveness, safety and advantages of High Thoracic Epidural Anesthesia (HTEA) combined with general anesthesia in terms of rapid extubation and post-operative pain control.

Materials and Methods: We retrospectively studied 19 patients (9 aortic, 9 mitral, 1 tricuspid valve) who underwent elective valvular cardiac surgery via right thoracotomy from 01.01.2003 to 01.12.2004. There were 12 male and 7 female patients. Mean age was 55.9 ± 7.9. Mean ASA Class was 2.6 ± 0.5 and mean Euroscore Class was 3 ± 2.3. HTEA was performed by insertion of a 19G catheter at Th2–Th3 level the day prior to surgery.

Epidural anesthesia was maintained by boluses of ropivacaine 1% 4 ml and general anesthesia with propofol 4–10 mg/kg/h. Patients were extubated while still in the operating room if respiratory and hemodynamic parameters were acceptable. Epidural analgesia was maintained with continuous infusion of ropivacaine 0.2% with fentanyl 5 mcg/ml at a rate 4–8 ml/h for 48 hours.

Pain scores (0 = no pain, 10 = worst pain) were recorded for 48 hours by a trained nurse.

Results and Discussions: Mean time of surgery and cardiopulmonary bypass were respectively 219 min ± 45 and 124 min ± 30, 16 patients (84.2%) were extubated in the OR. Mean time to extubation was 12 ± 7 min. No patient was reintubated. Mean pain scores were 1.8 ± 1.8 at 12 hrs, 1.2 ± 1.5 at 24 hrs and 0.8 ± 1.5 at 48 hrs. There were no adverse effects.

Conclusion(s): HTEA combined with general anesthesia in patients undergoing valvular surgery via right thoracotomy is safe, permits rapid extubation and guarantees optimal analgesia in the post-operative phase.

A-219

Lactate metabolism during SIRS induced by heated intraoperative intraperitoneal chemotherapy procedure

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Background and Goal of Study: Hyperthermic intraperitoneal chemotherapy (HIIC) for treatment of peritoneal carcinomatosis is an aggressive therapy, and may induce metabolic disorders. The aim of this prospective study was to analyse the changes in lactate metabolism in splanchic (S) and muscle tissue from (M) areas.

Materials and Methods: ASA 1 and 2 patients with cardiovascular or metabolic disease were excluded. The anesthetic protocol was the same for all patients, no lactate solution was infused. Arterial and venous (basilic and splanchic veins) lactate samples were drawn: just before the HIIC (T0) and after 90 min of HIIC (T1). Tissular Lactate utilization was estimated with lactate extraction: \[ \text{Ex}_{\text{lactate}} = \frac{\text{Lactate arterial}}{\text{Lactate venous}} \times 100 \] (%). A negative value means that the area is globally a lactate producer and conversely.

Statistics: Data (mean ± SD), Student t.

Results and Discussions: 43 patients included (7 M, 36 F).

<table>
<thead>
<tr>
<th>(mmol/l)</th>
<th>T0</th>
<th>T1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Art. lactate</td>
<td>0.96 ± 0.43</td>
<td>2.99 ± 1.23</td>
</tr>
<tr>
<td>S venous lactate</td>
<td>1.22 ± 0.38</td>
<td>3.17 ± 1.1</td>
</tr>
<tr>
<td>M venous lactate</td>
<td>1.1 ± 0.35</td>
<td>2.7 ± 1.1</td>
</tr>
<tr>
<td>Temperature (°C)</td>
<td>34.1 ± 0.8</td>
<td>38 ± 0.7</td>
</tr>
<tr>
<td>Vo2 (ml/min/m2)</td>
<td>134 ± 22</td>
<td>171 ± 35</td>
</tr>
</tbody>
</table>

\[ *p < 0.05 \text{T0 vs T1}, \, p < 0.05 \, S \text{ vs } M \]

Conclusion(s): HIIC induced a mild hyperlactatemia that is correlated with temperature augmentation. S and M areas were both lactate producers before HIIC, but M area became lactate consumer during HIIC; this fact confirm hypothesis that resting muscle may play an important role in lactate removing during metabolic stress.

Respiration

A-220

A-220

Comparison of volume- and pressure-controlled ventilation during laparoscopic bariatric surgery

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Background and Goal: Obesity has become a worldwide endemic problem. More and more bariatric surgery is performed, on more and more compromised patients. There are several surgical techniques, but the laparoscopic method has gained in frequency. Management of such patients faces the anesthesiologist with complex ventilatory problems. The purpose of the present study was to evaluate two ventilatory techniques (pressure (PCV) vs. volume controlled (VCV)) during laparoscopic bariatric surgery.

Materials and Methods: After Institutional Review Board approval, 20 adult consenting patients, scheduled for elective gastric banding operation were studied. Anesthesia was standardized: induction with remifentanil, propofol and rocuronium, and maintenance with TCI remifentanil and sevoflurane. Rocuronium was added if necessary. After an initial period of VCV with a tidal volume of 10 ml/kg and at a respiratory rate (RR) of 12 and surgical insufflation, the patients were allocated randomly to two groups: Group VCV (n = 10) received a tidal volume (Vr) of 10 ml/kg (ideal body...
weight (IBW) in VCV, and Group PCV (n = 10) with the airway pressure set to provide a PEEP of 10 mmHg. RR was adjusted to maintain an ETCO2 of 35–40 mmHg. Ventilatory variables were kept constant. Electrocardiogram, invasive radial arterial pressure, expired end-tidal carbon dioxide tension (ETCO2), airway pressures and arterial oxygen saturation were continuously monitored. The parameters were recorded with the RugoLoop® software. Data were analyzed with the Tukey-Kramer test. Data are mean (SD).

Results: No differences were found in the demographic characteristics of the two groups, nor in the values obtained before insufflation. The hemodynamic characteristics remained stable in the two groups. The pH and PCO2 values increased in both groups after surgical insufflation, but in the Group PCV this increase was higher as compared to the Group VCV (46.4 (3.72) vs. 43.5 (5.95) mmHg, p < 0.01).

Conclusions: Giving the difficulty of coping with CO2 elimination during one lung ventilation (OLV), we would recommend the use of FOB to provide a V T of 10 ml/kg IBW. RR was adjusted to maintain an ETCO2 of 3–5 kPa, and the single operator was asked to verify or readjust DLT placement following patient repositioning for thoracotomy. FOB was then performed to confirm a distance between the carina and the end of the tracheal lumen of 0.5–1.0 cm; to visualise the bronchial cuff inflation to ensure no herniation; to identify the left upper lobar bronchus and verify the distance from the origin of this and the end of bronchial lumen at 0.5–1.0 cm. Arterial blood gases were analysed ten minutes after onset of OLV and then at 30-minute intervals. If PaO2 was <9.5 kPa, DLT position was rechecked by FOB. The single operator was asked to check right-sided lung collapse using a 0–10 rating scale where 0 represented no deflation and 10 complete collapse.

A-224
Lung preservation during cardiopulmonary bypass
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Background and Goal of Study: Lung preservation during cardiopulmonary bypass (CPB) is controversial. Several studies have examined the best treatment to minimize the respiratory failure after cardiac surgery. In this study, we investigated three modalities of lung preservation during CPB.

Materials and Methods: The local Ethics committee approved this randomized, controlled prospective study. Sixty adult (age 18–80) patients undergoing elective cardiac surgery were randomly divided into three groups (20 patients each). Continuous positive airway pressure with air or 100% oxygen was given during CPB to patients in groups 1 and 2 (G1-Air, G2-O2). Patients in G3 were disconnected from the ventilator during CPB (G3-DC). Measurements and calculations of arterial blood gases (ABG), dynamic (Cdyn) and static Cstat lung compliance, PaO2/FIO2 ratio were performed after the induction of general anesthesia, prior to CPB and 30, 60, 120 and 240 minutes after discontinuation of the CPB.

Results: The ABG and respiratory parameters, between the groups, were done by using ANOVA. P < 0.05 was considered statistically significant.

Conclusion: The three methods were found to provide similar lung preservation during CPB. The selection of each of the methods, have a minor impact on postoperative lung function.

A-225
Effects of almitrine during anesthesia with sevoflurane for one lung ventilation
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Background and Goal of Study: Almitrine attenuates hypoxemia induced by one lung ventilation (OLV). Up to now, all the studies have been conducted during intravenous anesthesia, and there are not studies evaluating the association of sevoflurane and almitrine. Sevoflurane causes vasodilation and could counteract the vasodilation induced by almitrine. Our aim was to evaluate if almitrine can be useful to improve oxygenation during sevoflurane anesthesia for OLV.

Materials and Methods: Twenty consecutive patients undergoing open chest surgery and anesthesia with sevoflurane randomly received treatment (T) with placebo or almitrine (16 µg/kg/min). Respiratory and hemodynamic parameters were determined at the following times: room air (C), lateral decubitus with 100% O2 (2LV), after 20 minutes of treatment and before OLV (2LV + T), after 10, 20 and 30 minutes with open chest OLV.
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Effect of positive airway pressure during cardiopulmonary bypass on post-bypass oxygenation

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Background: Atelectasis is found in as many as 64% of chest radiographs after CPB and may cause hypoxemia, contrary to intravenous anesthesia; 2 – increases mPAP. It is controversial whether Continuous Positive Airway Pressure (CPAP) during CPB improves postoperative oxygenation (2). This study compared the effect of 0, 5 and 10 cmH2O CPAP during CPB on post-bypass oxygenation.

Methods: With Ethics approval, a randomised study of 48 patients having coronary artery bypass grafts was conducted. A standard anesthetic was given. The patients were in 3 groups receiving either 0, 5 or 10 cmH2O CPAP at FiO2 0.21 during CPB. In both 5 and 10 cmPAP groups, 5 cm PEEP was given. The patients were in 3 groups receiving either 0, 5 or 10 cmH2O CPAP during CPB on post-bypass oxygenation.

Results: Median [inter-quartile range] AaDO2 was used for analysis and p<0.05 considered significant.

Results and Discussion: There are no differences in the demographic data. 60% were right lobectomy and 40% left lobectomy.

Conclusions: Preliminary data suggest that almitrine, when routinely administered during anesthesia with sevoflurane for OLV: 1 – does not attenuate hypoxemia, contrary to intravenous anesthesia; 2 – increases mPAP.

References:

Acknowledgement: Grant from FIS 01/1586, Spain.

A-227

The effect of an alveolar recruitment strategy during one lung ventilation and the response to PEEP

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Background and Goal of Study: We studied the effect of the alveolar recruitment strategy (ARS) on gas exchange during OLV and the effect of the positive end expiratory pressure (PEEP) on the extravascular lung water (ELWI) in patients under thoracic surgery.

Materials and Methods: Prospective observational trial that includes 10 cases of thoracic surgery with OLV. These data are preliminary because the study is still open. The ARS was applied selectively to the dependent lung after the thorax opening with the patient on lateral position. Previously we maintained the OLV ventilation: IPPV, VT 6–8 ml/Kg, PEEP 0, FR 12–16. ARS protocol: Respiratory frequency 15 rpm, PIP and PEEP were sequentially increased from 30/10 to 40/20 in steps. After ARS we maintained PEEP of 6 in all patients. The FiO2 was the necessary to keep Sat O2 > 90%. Data collected: demographic, ASA, arterial blood gases, haemodynamic parameters with PICCO Plus, and respiratory parameters. The patients were studied at (A)15 min after open thorax with OLV and just before ARS, (B) 15 minutes after ARS, (C)At the end of the surgery.

Results and Discussions: There are no differences in the demographic data. 60% were right lobectomy and 40% left lobectomy.

Conclusions: Our ARS is effective to improve the oxygenation and the respiratory parameters during OLV.

References:

A-228

Pressure control versus volume control ventilation during anesthesia – preliminary study

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Background and Goal: Pressure control ventilation (PCV) is a widely used mode of ventilation in mechanically ventilated patients in ICU. The goal of this prospective study is to assess the role of PCV on the respiratory mechanics and arterial oxygenation at different patients during anesthesia under PCV versus volume control ventilation (VCV).

Materials and Methods: 17 ASA I-II, mean age 61.53 years, undergoing general anesthesia were studied. Laparoscopic surgery was excluded. Preoperative PaO2 (mmHg) was recorded. Patients were ventilated by a Julain-Drager anesthesia machine with either VCV at settings: FiO2 = 0.5%, tidal volume 8–10 ml/kg, time I:E = 1:2, PEEP = 5, for 30 minutes. PaO2, PaCO2 (mmHg), airway pressures (mbar), ETCO2 (mbar) and pulmonary compliance (Compl/ml/mbar), were recorded. Then the machine was switched to PCV adjusting to deliver the same settings as for VCV for 30 min and the same set of measurements performed. The percentage of difference of parameters between the two modes was calculated.

Results and Discussion: Data results (mean (SD)) are shown in the table:

<table>
<thead>
<tr>
<th></th>
<th>Before ARS</th>
<th>After ARS</th>
<th>End of surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>PaO2</td>
<td>117 ± 0.7</td>
<td>147 ± 10</td>
<td>140 ± 2.8</td>
</tr>
<tr>
<td>Compliance</td>
<td>20 ± 4</td>
<td>28.5 ± 5.2</td>
<td>29 ± 4</td>
</tr>
<tr>
<td>ELWI</td>
<td>9 ± 4</td>
<td>7.5 ± 3</td>
<td>8.5 ± 2</td>
</tr>
</tbody>
</table>

80% of the patients improve the PaO2 after the maneuver, at the beginning ELWI decreases but at the end of the surgery is similar to the previous value.

References:
1. 33.

A-229

A new software for computed tomography lung measurement

Department of Anesthesia and Critical Care, Policlinico Hospital, Milano, Italy

Background and Goal of Study: The use of computed tomography (CT) in the management of ALI/ARDS patients is quite common, due to the possible
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Repeatability of the quantitative analysis of lung computed tomography in ALI/ARDS patients

Institute of Anesthesia and Critical Care, Policlinico Hospital, Milano, Italy

Background and Goal of Study: The CT scan allows an accurate morphologic analysis of an “ARDS” lung in addition with the spiral CT it is also possible a quantitative analysis using dedicated software. However due to the necessity of a manually drawing of the lung (i.e., to include the lung parenchyma and to exclude big vessels, trachea, pleural effusion,…) it would be possible to increase the error of the analysis.

Aim of this study was to evaluate the accuracy of analysis between trained physician (4 medical doctor) and two radiology.

Materials and Methods: We enrolled 12 intubated sedated paralyzed ALI/ARDS patients (mean age 63.5 ± 16.9 years, BMI 24.1 ± 4.7 Kg/m², ventilated with a tidal volume of 532 ± 195 ml, PEEP 11.2 ± 1.9 cmH₂O, PaO₂/FI0₂ 205 ± 57).

The CT scan was performed independently from this study.

The CT scan was done, in static conditions, at end expiration 5 or 15 cmH₂O of PEEP and at end inspiration 45 cmH₂O of airway pressure. The exposures were taken at 120 KV and 250 mA.

The lung volume, weight and the distribution of lung weight between the different compartments was measured using the “Maluna” software (University of Mannheim, Germany).

Results and Discussions: Results are expressed as mean ± standard deviation.

<table>
<thead>
<tr>
<th></th>
<th>Physicians</th>
<th>Radiology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total volume (ml)</td>
<td>3956 ± 1608</td>
<td>3588 ± 1664</td>
</tr>
<tr>
<td>Total weight (mg)</td>
<td>1419 ± 471</td>
<td>1391 ± 449</td>
</tr>
<tr>
<td>Weight hyperinflated (mg)</td>
<td>41 ± 79</td>
<td>41 ± 82</td>
</tr>
<tr>
<td>Weight normally inflated (mg)</td>
<td>442 ± 160</td>
<td>440 ± 164</td>
</tr>
<tr>
<td>Weight poorly inflated (mg)</td>
<td>439 ± 269</td>
<td>419 ± 270</td>
</tr>
<tr>
<td>Weight not inflated (mg)</td>
<td>498 ± 350</td>
<td>489 ± 362</td>
</tr>
</tbody>
</table>

Conclusion(s): These show that the quantitative analysis although required a physician to manually drawing the region of interest of the lung, present a very low of inaccuracy.

A-232

The variability of indices of oxygenation

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Background and Goal of Study: Quantification of the impact of oxygenation allows monitoring of critically ill patients’ disease severity and treatment efficacy and allows stratification for research. Current indices include PaO₂/FI0₂ and venous admixture (QS/QT). Although these have been shown to be dependent upon FI0₂, they are widely used. Previous investigators used a lung model to examine the effect of FI0₂ on PaO₂/FI0₂ and QS/QT. The model lacked tidal ventilation and hypooxic pulmonary vasoconstriction (HPV). Our aim was to re-examine the relationship using a sophisticated pulmonary model.

Materials and Methods: Extra-pulmonary shunt fractions of 10–40% of cardiac output were set in a validated, computational model of the human respiratory system, and ventilation-perfusion defects were added to attain a measured shunt fraction of 40% of cardiac output at FI0₂ 0.3. Tidal volume was adjusted to set PaCO₂ at 5.1 kPa at FI0₂ 0.3. We varied FI0₂ from 0.3 to 1.0 and recorded the resulting values of PaO₂/FI0₂ and QS/QT.

Results and Discussion: In the figure, open symbols describe QS/QT and solid symbols describe PaO₂/FI0₂. Both varied with changing FI0₂. The induced variation in PaO₂/FI0₂ and QS/QT differed from previous findings.

A-233

Intraoperative lung water changes: correlation with pulmonary edema after liver transplantation

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Background and Goal of Study: In patients undergoing orthotopic liver transplantation (OLT), intrathoracic blood volume (ITBV) has been shown to increase after reperfusion and to influence pulmonary function. The pulmonary edema is common after OLT and will influence postoperative recovery in transplant patients (2). This study was designed to determine the incidence of radiological pulmonary edema in the first 24 hours after transplantation and its relationship with intraoperative extravascular lung water (ELWI) changes.

Materials and Methods: We reviewed 87 chest radiographs from 29 patients who had undergone OLT, obtained before surgery, immediately after surgery and 20–24 hours after surgery. Films were assessed for evidence of pulmonary edema using a standardized system (3). ITBV and ELWI were
determined using the PICCO system, pulmonary capillary wedge pressure (PCWP) was monitored through a pulmonary artery catheter. Volumetric, hemodynamic and oxygenation index changes (Δ) were collected intraoperatively and at the times the 2 postoperative films were obtained. Blood loss, duration of ventilation and ICU stay was also recorded.

Results and Discussions: The incidence of postoperative pulmonary edema (PE) was 55%.

<table>
<thead>
<tr>
<th>Child's class (A/B/C)</th>
<th>PE (n = 13)</th>
<th>No PE (n = 13)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICU stay (days)</td>
<td>8 ± 5</td>
<td>11.2 ± 8</td>
</tr>
<tr>
<td>Ventilation (hours)</td>
<td>5.5 ± 1.7</td>
<td>110 ± 117*</td>
</tr>
<tr>
<td>Blood loss (L)</td>
<td>3.5 ± 2</td>
<td>3.2 ± 1.9</td>
</tr>
<tr>
<td>JPCWP (%)</td>
<td>18 ± 24</td>
<td>49 ± 49*</td>
</tr>
<tr>
<td>JPCWP (%)</td>
<td>37 ± 43</td>
<td>31 ± 26</td>
</tr>
<tr>
<td>JPaFi (%)</td>
<td>26 ± 16</td>
<td>34 ± 17</td>
</tr>
</tbody>
</table>

Results in mean ± SD, “*” P < 0.05.

Conclusion(s): Postoperative radiological edema was found in 55% of patients and was associated with longer ventilatory support and with intraoperative increases in ELWI. Monitoring ELWI changes may predict patients at risk for pulmonary edema after liver transplantation.

References:

A-234
The effect of lung-protective ventilation – a new viewpoint of pathological share forces
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Background and Goal of Study: “Open up and keep the lung open” (1) is a discussed concept in the last years of lung protective ventilation avoiding share forces by cyclic reopening of atelektasis. Explaining normal lung volume change by alveolar recruitment/decrutment (R/D), there is a discrepancy for understanding ventilator induced lung injury (VILI).

Materials and Methods: In a mathematical model we define two populations with different surfactant concentrations, that means with a different opening and closing behavior. Pressure-dependent compliance curve represents a normal distribution of opening pressures. PV-Diagram represents the sigmoid integral curve of distribution, that means the number of opening/closing alveolar units at a defined transpulmonary pressure tp.

Results and Discussions: In a R/D-Model we have stable situations in the regions of the asymptotes of the PV-curve: most of alveolar units are opened or closed. The inflection point reflects the most instable state: a little drop of tp leads to a great change of opened or closed alveolar units. In a region with nearly the same surfactant content, this will not produce a great number of shear forces, so that a ventilation with a drop of tp within the mean alveolar opening pressure of the second population (high PEEP, low driving pressure) will have a lung-protective character. A ventilation with a drop of tp having a span from one mean alveolar opening pressure of the first population to the other of the second population, will produce pathological share forces with VILI.

Conclusion(s): Lung-protective ventilation can be explained by avoiding pathological share forces between two different populations (with their own R/D-behavior) maintaining the simple R/D-Model for lung volume change in accord with visualizing studies of the last years (2,3).

References:

A-235
Functional residual capacity assessment during open and closed tracheo-bronchial suctioning
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Background and Goal of Study: The method of functional residual capacity (FRC) evaluation by oxygen washout is applicable routinely at bedside, in controlled ventilation as well as in spontaneous breathing patients (1). We studied the impact of two different suctioning methods on FRC.

Materials and Methods: The LUFU system (Draeger, Luebeck, Germany) estimates FRC by oxygen washout, a variant of multiple breath nitrogen washout. A sidestream O2-analyser calculates FRC from the end-inspired and end-expired O2 concentrations during fast changes of FiO2. After approval of the local ethics committee and written informed consent we measured FRC six times (measuring interval 4 min.) in postoperative cardiac surgery patients without pre-existing lung diseases during 6 hours after surgery; 3 times before (the mean defined as basal value (pre) and 3 times after (t1, t2, t3) a standard suctioning procedure (20 sec, 14 F catheter, 200 mmHg negative pressure). The patients were ventilated with biphasic airway pressure ventilation. The control group (n = 7) was disconnected from the ventilator during suctioning (Open suctioning [OS]), while in the intervention group (n = 7) a closed-suctioning system (Kendall Comp., Mansfield, USA) was used and so positive airway pressure was maintained (Closed suctioning [CS]).

Results and Discussions: There were no technical problems during measurements. FRC remained unchanged in group CS (3.3 ± 1.51 [pre]; 3.4 ± 1.21 [t3] (n.s.)) and decreased significantly in group OS (3.3 ± 1.5 [t1]; 2.9 ± 1.51 [t2], p = 0.028; 3.0 ± 1.31 [t3], p = 0.018 (Mean ± SD, Wilcoxon-Test). There were no differences between the two groups at any time point. There were strong inter individual differences in both groups, not only in total values, but also concerning the time course after OS or CS.

Conclusion(s): OS reduces FRC immediately after suctioning. The consequences of different suctioning procedures cannot be predicted because of strong inter individual differences, so it seems to be of considerable interest to measure FRC in ventilated patients routinely. Larger studies are recommended to address this issue.

Reference:

A-236
Elimination of PFC during partial liquid ventilation in open and closed breathing systems
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Background and Goal of Study: So far, partial liquid ventilation has only been performed with open breathing systems. The elimination of perfluorocarbons (PFC), which is mainly due to evaporation via the bronchial system, is determined by its physical and chemical properties as well as the ventilatory settings (1). We tested the hypothesis that the amount of eliminated PFC can be significantly reduced by closed circle ventilation. Moreover, we examined whether the use of a heat and moisture exchanger (HME) influences the elimination rate. This is clinically relevant as the eliminated PFC volume needs to be replaced during partial liquid ventilation.

Materials and Methods: With approval of the local District Animal Investigation Committee, male Wistar rats (n = 7) were anaesthetised with ketamine. The trachea, heart and lungs were removed en bloc and suspended from a force transducer. The lungs were ventilated with a tidal volume of 10 mL/kg, a respiratory rate of 40 breaths per minute and an I/E-ratio of 1:1 with an open breathing system (FiO2 = 0.21). Thereafter, PFC was instilled into the trachea (10 mL/kg) and the evaporative loss was determined by means of change in lung weight. After baseline values have been reached, the same amount of PFC was again instilled and the lungs were then ventilated with a closed circuit system. In additional pilot lungs (n = 3) the same amount of PFC was instilled and the lungs were ventilated with an open breathing system with an HME attached between the tracheal tube and the respirator.

Results and Discussions: The elimination half-life of PFC during partial liquid ventilation was significantly longer in a closed circle system than in an open breathing system. (557 ± 179 min. vs. 83 ± 7 min, mean ± SD; p < 0.001, t-test). Longer half-lives (above 10 hours) were also observed with an HME.

Conclusions: Ventilation with a closed circle system significantly reduces perfluorocarbon elimination during partial liquid ventilation. Similar effects are observed with an HME.
A-237
Combined application of perfuorohexan vapor and optimization of PEEP does not improve oxygenation significantly
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Background and Goal of Study: The inhalative application of perfuorohexan vapor (PFFH) improves oxygenation and mechanical lung function in oleic acid-induced lung injury [1,2]. The surfactant-like characteristics of PFFH have been discussed as a possible explanation. A study using a surfactant-depletion injury model showed less positive effects [3]. The aim of this study was to determine the effects of PFFH on oxygenation and relative lung perfusion distribution (Qrel) at different PEEP levels.

Materials and Methods: All experiments were performed in accordance with local Government Guidelines. After induction of anaesthesia 15 rabbits were ventilated (volume controlled FIO2 = 1.0; PEEP = 5 mmHg) and monitored. Lung injury was induced with NaCl-lavage. After randomization eight animals were receiving 3H OA the experiment was terminated 45 minutes after OA infusion. In the 4 animals controls, OA 0.1 ml/kg was given as a 30 minute infusion. In the 4 animals extrapulmonary tissues.

A-238
Extrapulmonary effects of the oleic acid lung injury model
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Background and Goal of Study: Oleic acid (OA) lung injury is thought of as a local lung injury model. We tested the hypothesis that OA infusion, besides its pulmonary effects, has intrinsic effects on intestinal circulation, metabolism and oxygenation. Further, we aimed to study the distribution of OA to extrapulmonary tissues.

Materials and Methods: 17 juvenile female pigs were studied. 4 animals received 3H-labeled OA. 7 animals received OA and 6 animals served as controls. OA 0.1 ml/kg was given as a 30 minute infusion. In the 4 animals receiving 3H OA the experiment was terminated 45 minutes after OA infusion, and tissue samples from lungs, liver, stomach, jejunum and colon was analyzed for 3H OA radioactivity. In the other 2 groups animals were followed for 240 minutes with measurements of portal blood flow, jejunal mucosal perfusion, jejunal tissue oxygenation, mesenteric lactate flux and mesenteric oxygen delivery and extraction.

Results and Discussions: OA was found in all tissues studied, albeit in small amounts in the intestines (Table 1).

Table 1. % recovered 3H activity of given dose.

<table>
<thead>
<tr>
<th>Tissue</th>
<th>3H Activity (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lung</td>
<td>16.6 ± 3.4</td>
</tr>
<tr>
<td>Liver</td>
<td>9.0 ± 0.5</td>
</tr>
<tr>
<td>Stomach</td>
<td>0.3 ± 0.1</td>
</tr>
<tr>
<td>Jejunum</td>
<td>1.0 ± 0.3</td>
</tr>
<tr>
<td>Colon</td>
<td>0.4 ± 0.1</td>
</tr>
</tbody>
</table>

OA infusion caused a moderate lung injury with expected pathophysiologic-circulatory and ventilatory derangements. For a given mesenteric oxygen delivery, mesenteric oxygen uptake was consequently higher after OA infusion in the OA group than in the control group.

Conclusion(s): OA is distributed in small amounts to the intestine in the OA lung injury model. We found an increase in mesenteric oxygen uptake relative to delivery in the OA group, possibly due to local inflammation.

Acknowledgement: We wish to thank Professor Gunilla Olivecrona and Professor Björn Biber for valuable exchange of ideas.

A-239
Endothelin-1 impairs alveolar liquid clearance and accelerates edema formation in normoxia and hypoxia
M.M. Berger, C. Schieber, M. Dehier, H.J. Bardenheuer, P. Bartsch, M. Haibairt
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Background and Goal of Study: Noncardiogenic pulmonary edema occurs in many clinical conditions associated with alveolar hypoxia (e.g., acute lung injury, drug side effects) or high-altitude exposure. The basic mechanisms leading to edema formation remain uncertain and might include increased capillary pressure, altered vascular permeability, and reduced alveolar liquid clearance. Because endothelin-1 (ET-1) plasma levels are elevated during hypoxia, we investigated the effects of ET-1 on hypoxic pulmonary edema formation in isolated ventilated and perfused rat lungs.

Materials and Methods: Lungs were perfused with albumin–containing salt solution at constant hydrostatic pressure and exposed to normoxia (N) or hypoxia (H, 1.5% O2) with or without ET-1 (0.8 μM) added to the perfusate. To assess pulmonary edema formation, increases in lung weight and survival time (time until tidal volume decreased to 0) were monitored. Microvascular pressure was measured by double occlusion. In separate experiments, net fluid transport across alveolar epithelium was estimated by measuring the re- sorption of instilled buffer that contained FITC-dextrane as alveolar marker.

Results and Discussion: H and ET-1 accelerated lung weight gain (minutes ± SEM to reach 1000 mg: N 261 ± 17; H 175 ± 20; ET-1 157 ± 12; p < 0.003, One-Way ANOVA) and reduced lung tissue fluid volume (H 53.4 ± 8.9% and ET-1 45 ± 3.4%; p < 0.001). Fluid reabsorption was ± 23.9 ± 9.7% in N. In contrast, H (-19.4 ± 13.8%) and ET-1 (-23.1 ± 13.7%) caused net fluid accumulation (p < 0.05). These effects were aggravated by combination of H with ET-1. H, but not H, increased microvascular pressure (11 ± 1.5 vs. N 1.5 ± 0.5 cm H2O; p < 0.001) and alveolar protein concentration (236 ± 61% vs. N; p < 0.05), indicating that a hydrostatic component with increased vascular permeability contributes to ET-1 (but not necessarily to H)-induced pulmonary edema.

Conclusions: This is the first study indicating that ET-1 reduces alveolar liquid clearance, a mechanism that, in combination with increased pulmonary microvascular pressure and increased vascular permeability, might contribute to formation of pulmonary edema. Hypoxia seems to aggravate the effects of ET-1.

A-241
Increased pulmonary PDE activity is responsible for hyporesponsiveness to inhaled nitric oxide
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Background and Goal of Study: Pulmonary hyporesponsiveness to inhaled nitric oxide (iNO) is an unresolved clinical phenomenon (1). Pulmonary vasoreactivity (pVR) to iNO is impaired in rats 2–18 hours after Lipopolysaccharid (LPS)-challenge (2). The goal of this study was to test the role of the PDE in endothoxemia by application one PDE sensitive (8-BrcGMP) and one insensitive (8-pCPT-cGMP) GMP analogue in isolated lungs over 24 h.

Materials and Methods: Adult Sprague-Dawley rats (300–350 gm BW) were injected ip. with (n = 34) or without (n = 9) 0.5 mg/kg E.coli 0111:B4 LPS, 2, 10 and 18 hours after LPS, lungs were isolated perfused. Then, pulmonary artery pressure (PAP) was elevated by 6–8 mmHg using U46619. Change of PAP (%) in response to 10−10 M and 10−5 M of cGMP analogues was measured.

Results and Discussions: In controls both analogues induce an equal pVR. In LPS-treated rats no change of pVR to 8-pCPT-cGMP at 2, 10 or 18 h compared to untreated controls was detected. In contrast, 8-BrcGMP resulted only in a slight pVR 2, 10 and 18 h after LPS-challenge.

# p < 0.05 vs. control, § p < 0.05 vs. 8-BrcGMP mean ± SEM.
Conclusion(s): The pVR after 8-Br-cGMP in isolated perfused lungs after LPS-stimulation is reduced compared with lungs treated with 8-cGMP indicating an increased PDE activity in the lung in endotoxaemia over 18 h. Especially in early endotoxaemia this mechanism could play an important role in the development of hyporesponsiveness to NO.

References:

A-242

Anti-inflammatory effect of sevoflurane in endotoxin-induced lung injury

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Background and Goal of Study: Endotoxin-induced lung injury is a very useful experimental system for the characterization of immunopathogenic mechanisms in acute lung injury. The inflammatory response of alveolar epithelial cells (AEC) to lipopolysaccharide (LPS) has been shown in previous studies (1). Although tracheal, bronchial and alveolar epithelial cells are exposed to volatile anaesthetics throughout the duration of anaesthesia, only rare data exist about the effect of anaesthetics on these lung cells. The purpose of this study was to investigate the effect of the volatile anaesthetic Sevoflurane on LPS-injured AEC.

Materials and Methods: AEC cells were exposed to 1.1 Vol.% Sevoflurane for 0.5 h (control group without Sevoflurane), followed by LPS stimulation for 5 h (or stimulation with phosphate-buffered saline as a control). Proteins from chemottractant protein-1 (MCP-1), cytokine-induced-neutrophil-chemotactant-1 (CINC-1), and macrophage inflammatory protein-1β (MIP-1β) were analysed in the supernatant with ELISA and Western blot technique. In addition, chemotaxis assays were performed with neutrophils. Analysis of variance (ANOVA) was used to assess the statistical significance of differences.

Results and Discussions: Exposing cells to Sevoflurane showed a 50% decrease regulation of MCP-1 protein in the Sevoflurane-LPS group compared to Non-Sevoflurane-LPS cells (p < 0.05). CINC-1 concentration in LPS-stimulated cells decreased by 20% (p < 0.05) with Sevoflurane pre-treatment. MIP-1β concentration by 32% (p < 0.05). Chemotaxis assays showed less chemotactic activity in Sevoflurane-treated LPS cells (33% decrease, p < 0.001).

Conclusion(s): This study shows for the first time a protective effect of the volatile anaesthetic Sevoflurane regarding production of inflammatory mediators in the LPS-induced lung injury.

Reference:

Acknowledgement: This grant was supported by Abbott, Switzerland, and the Lungenliga, Switzerland.

A-243

Regulation of the cellular expression of the new lung-specific protein hypoxia-induced mitogenic factor (HIMF)

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Department of Anesthesiology, University Luebeck, Luebeck, Germany

Background and Goal of Study: In chronic hypoxia, the integrity of the alveolar-capillary unit of the lung is disturbed. Hypoxia Induced Mitogenic Factor (HIMF) has been implicated in the cellular proliferation during lung maturation as well as in chronic hypoxic lung disease. To date, little is known about the factors regulating HIMF.

Materials and Methods: Therefore, cell line screening for HIMF expression, recombinant HIMF over-expression, siRNA and two-hybrid analysis were employed to approach HIMF expression regulation.

Results and Discussions: Recombinant, tagged HIMF was produced in a yeast expression System. To standardize the different batches of recombinant HIMF a bioassay using adipocytes was developed. Primary rat type II pneumocytes showed little HIMF expression at baseline but hypoxia (3% O2) significantly induced HIMF protein. Since HIMF has a n-terminal secretion sequence we were interested to analyze the cellular pathways of HIMF secretion. Using siRNA technology we investigated the effect of a knock down of components of the protein transport pathway on HIMF secretion.

Conclusion(s): We characterized in detail factors of the regulation of HIMF expression. Interference with HIMF secretion might prevent pulmonary remodeling characteristic of chronic obstructive lung disease.

Reference:

Acknowledgement: Supported by the University Luebeck (KFW) and the NIH (to DL, KFW R01 HL7555-01).

A-245

The influence of acute hypercapnia and priming of 10 ng/kg endotoxin on oxidative metabolism of bronchoalveolar lavage-derived alveolar macrophages in mechanically ventilated rabbits

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Background and Goal of Study: Permissive hypercapnia can attenuate tissue injury connected with phagocyte stimulation and respiratory burst. It is also known that endotoxin (LPS) translocation and mechanical ventilation might modify the function of phagocytes and reactive oxygen intermediates (ROI) production. In this study we investigated endotoxin priming stimulation on rabbit’s alveolar macrophages (AM) derived from bronchoalveolar lavage (BAL) after normocapnic and isoxic hypercapnic mechanical ventilation.

Materials and Methods: The 40 Chinchilla rabbits were randomised into 4 groups: normocapnic (N), normocapnic with endotoxin (NE), hypercapnic (H), hypercapnia with endotoxin (HE) were anaesthetised with sodium pentobarbital and intubated. After 30 min 10 ng/kg LPS Escherichia coli was intravenously injected in the NE and HE groups. In the H and HE groups 5% CO2 was added to the mixture of air and O2 during ventilation and created PaCO2 between 8-10.7 kPa. After 4 h of mechanical ventilation the bronchi were rinsed with 40 mL of isotonic saline. BAL cells were counted. Luminol-dependent chemiluminescence (ChL) was used to estimate the hydrogen peroxide production with activating stimuli: zymosan (ZY), phorbol myristate acetate (PMA) and N-formylmethionyl-leucyl-phenylalanine (fMLP). Results were analysed by Kruskal-Wallis and Dunn tests.

Results: Data (Mean and SD) are shown in the table.

<table>
<thead>
<tr>
<th>AM/BAL 1 x 10^6/mL</th>
<th>ChL ZY (Vs)</th>
<th>ChL PMA (Vs)</th>
<th>ChL fMLP (Vs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>0.7 ± 0.51</td>
<td>9.97 ± 9.57</td>
<td>4.25 ± 5.67</td>
</tr>
<tr>
<td>NE</td>
<td>2.47 ± 0.84</td>
<td>30.04 ± 17.01</td>
<td>10.76 ± 10.77</td>
</tr>
<tr>
<td>H</td>
<td>0.31 ± 0.34</td>
<td>21.93 ± 27.75</td>
<td>14.60 ± 11.00</td>
</tr>
<tr>
<td>HE</td>
<td>1.8 ± 1.30</td>
<td>8.78 ± 5.41</td>
<td>2.07 ± 1.98</td>
</tr>
</tbody>
</table>

*p < 0.005 HE vs N and H; p* < 0.005 NE vs N and H.

Conclusions:
1. Acute hypercapnia does not influence the alveolar macrophages count and hydrogen peroxide production.
2. Priming with 10 ng/kg of LPS increased the alveolar macrophages number in BAL, in mechanically ventilated rabbits without direct impact on BAL cells oxidative metabolism.

A-246

Transtracheal ventilation at different degrees of upper airway obstruction evaluated with a mechanical lung model

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Background and Goal: In a “can’t intubate, can’t ventilate” crisis insertion of an endotracheal tube (ETT) through the cricothyroid membrane can be live-saving (1). We studied the performance of 4.0 and 6.5 uncuffed ETTs at different degrees of upper airway obstruction and lung conditions using a mechanical lung model (VT-1).

Materials and Methods: The VT-1 (Bio-Tek, USA) can simulate normal lung, COPD and emphysema. Corrugated tubing was used as a tracheal model and connected to the inlet (internal diameter (ID) 12 mm) of the VT-1. A Y-piece was attached to the top of the “trachea”. Through one arm ETTs were inserted via a seal until tip was mid trachea. At the other arm different degrees of outflow obstruction from total to no obstruction were set. Ventilation was with an Ambu Bag, using both hands, and uncuffed ETTs size 4.0 and 6.5.

Results and Discussions: With 100% outflow obstruction both ETTs 4.0 and 6.5 provided adequate ventilation regardless of the underlying lung condition. With an ETT 4.0 tidal volumes of over 750 ml and minute volumes of over 8 l/min were achieved. ETT 6.5 achieved similar tidal volumes, but higher minute volumes of over 12 l/min. With less obstruction more air bypassed the ETT on inspiration with decrease in lung ventilation. Ventilation of normal lungs with an ETT 4.0 and 50% obstruction (ID 6 mm) reduced tidal volumes to around 200 ml with a corresponding minute volume of...
around 6.5 l/min. 50% obstruction in COPD and emphysema caused a drop in tidal volumes to around 100 ml/s and 80 ml/s respectively. Minute ventilation dropped below 2 l/min. At low levels of obstruction minute volume approached zero. A similar pattern of worsening ventilation was recorded for the ETT 6.5 although the critical level of obstruction at which ventilation becomes inadequate is lower.

Conclusion: The use of uncuffed ETTs (4.0, 6.5) in transtracheal ventilation with partial or no upper airway obstruction led to ineffective ventilation, in particular with pre-existing lung disease. Complete upper airway obstruction or the use of cuffed ETTs resulted in effective ventilation.

Reference:

A-247

High frequency jet ventilation for airway control in patients with short fat neck


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Background and Goal of Study: Standard mechanical ventilation (SMV) through endotracheal tube (ETT) is widely used for percutaneous tracheostomy (PCT). Short fat neck (SFN) is considered as a relative contraindication for PCT, mainly because of possibility for airway complications. We decided to examine our experience of airway control and ventilation by SMV and by high frequency jet ventilation (HFJV) during PCT in patients with SFN and to determine which is more effective.

Materials and Methods: From January 1998 to June 2000, 23 patients (pts) with anticipated difficult airways (short fat neck) were intubated under Griggs technique with SFN and from July 2000 to November 2001, 25 pts with HFJV. One trained team performed all the PCT. In the HFJV group, a Cook catheter was inserted through the existing ETT into the upper part of the trachea and HFJV was initiated by a special ventilator AMS-1000 AUTRONIC. Then ETT was withdrawn into the mouth along the catheter. When PCT was finished, the Cook catheter was removed together with ETT. During PCT continuous routine monitoring and repeated blood gas analyses were performed.

Results and Discussions: There was no significant statistically difference between the two groups in the sizes of the neck (mean, median, range, p = 0.9) and distance between cricoid and sternal notch (mean, median, range, p = 0.8). Duration of the procedure for the two groups was identical. When SMV was used, impaling of ETT and cuff rupture has happened in one case, displacement of ETT into the pharynx took place in 3 cases (due to short larynx). Air leak from larynx around ETT and additional egress of air from tracheotomy site during the time of the dialage was the reason for pronounced desaturation in 7 pts. PCT with HFJV passed smoothly: small air leak did not influence on the level of oxygenation, only an increase in PaCO2 values in acceptable limits was found. The difference between SMV and HFJV was statistically significant (p < 0.001).

Conclusion(s): SMV can not always supply necessary conditions for PCT in pts with SFN and there are possibilities for development of serious complications. HFJV through Cook catheter provides optimal conditions for manipulation on SFN, secures success of the procedure and prevents potential airway complications.

A-248

Measurement of movement of field of illumination provided by laryngoscope blades under tension

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Background and Goal of Study: Direct laryngoscopy is the most common technique used to intubate the trachea. In recent years concerns about risks of cross-infection have led to the increasing use of disposable laryngoscope blades. The International Organization for Standardization (ISO) proposed a working draft to measure the movement of the field of illumination provided by laryngoscope blades under tension [1]. We carried out this test on both metal and plastic disposable blades.

Materials and Methods: We assessed 14 adult and 12 paediatric laryngoscopy blades from various manufacturers comparing the shift in illumination under tension (58 N) to that recommended in the ISO draft. The draft proposed that there should not be more than 12 mm shift of luminal edge. The shift in the tip of illuminated edge was manually measured by using standard graph paper marked in millimetres.

Results and Discussions:

<table>
<thead>
<tr>
<th>Blade</th>
<th>m/p</th>
<th>FOV</th>
<th>BQ</th>
<th>ES</th>
<th>Time [s]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timescos Europa m</td>
<td>86</td>
<td>86</td>
<td>81</td>
<td>81</td>
<td>4 [1]</td>
</tr>
<tr>
<td>Timescos Callisto m</td>
<td>86</td>
<td>84</td>
<td>77</td>
<td>20</td>
<td>4 [2]</td>
</tr>
<tr>
<td>Proact Mmax 100 m</td>
<td>83</td>
<td>86</td>
<td>79</td>
<td>29</td>
<td>5 [1]</td>
</tr>
<tr>
<td>Ruphatek Greenlite m</td>
<td>82</td>
<td>80</td>
<td>70</td>
<td>21</td>
<td>5 [1]</td>
</tr>
<tr>
<td>Reusable Miller 1 m</td>
<td>81</td>
<td>83</td>
<td>78</td>
<td>22</td>
<td>5 [2]</td>
</tr>
<tr>
<td>Proact Metalmax 90 m</td>
<td>80</td>
<td>85</td>
<td>77</td>
<td>20</td>
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<tr>
<td>Proact Mmax G590 m</td>
<td>77</td>
<td>80</td>
<td>69</td>
<td>33</td>
<td>4 [1]</td>
</tr>
<tr>
<td>Timescos Optima p</td>
<td>67</td>
<td>40</td>
<td>37</td>
<td>36</td>
<td>5 [2]</td>
</tr>
<tr>
<td>Penlon Crystal p</td>
<td>64</td>
<td>37</td>
<td>33</td>
<td>33</td>
<td>6 [2]</td>
</tr>
<tr>
<td>Vivatex p</td>
<td>57</td>
<td>22</td>
<td>24</td>
<td>35</td>
<td>5 [3]</td>
</tr>
<tr>
<td>Intersurgical p</td>
<td>55</td>
<td>33</td>
<td>27</td>
<td>37</td>
<td>6 [4]</td>
</tr>
<tr>
<td>Ruphatek Liteblade p</td>
<td>46</td>
<td>36</td>
<td>29</td>
<td>36</td>
<td>7 [5]</td>
</tr>
</tbody>
</table>

Conclusion: Not all disposable blades offer similar performance. Anaesthetists appear to prefer metal over plastic disposable blades.

Reference:

Acknowledgement: Grant from Royal College of Anaesthetists, Great Britain.

A-250

Laryngoscope assisted orotracheal fibreoptic intubation in anticipated difficult airways

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Background and Goal of Study: Orotracheal fibroptic intubation (OFI) under general anaesthesia, without the use of intubating airways, requires manoeuvres or instruments to clear the airway (1, 2). The study compared OFI when using the Macintosh laryngoscope (ML) or lingual traction plus jaw thrust (LT) to clear the airway.

Materials and Methods: Following ethics committee approval and informed consent, 30 adult ASA class I or II, patients with at least one difficult intubation criteria (3), received standardized general anaesthesia (comprising fentanyl, propofol, atracurium, oxygen, nitrous oxide, isoflurane) and were randomly allocated to the ML or LT groups for OFI. A stopwatch (lap) recorded preparation time (from mask removal to starting endoscopy).
endoscopy time, railroading time and total intubation time (to CO₂ detection). Cardiovascular responses were recorded for each group.

**Results and Discussions:** Time data, in seconds, are shown in the table (Mean (SD) [range] *P < 0.05):

<table>
<thead>
<tr>
<th>Time phase</th>
<th>LT</th>
<th>ML</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparation</td>
<td>13 (2.3) [9–17]</td>
<td>9.6 (2.9) [6–16]</td>
</tr>
<tr>
<td>Endoscopy</td>
<td>11 (3.0) [6–17]</td>
<td>8.7 (2.1) [6–13]</td>
</tr>
<tr>
<td>Railroading</td>
<td>7.1 (1.7) [5–10]</td>
<td>5.9 (2.2) [5–9]</td>
</tr>
<tr>
<td>Total intubation</td>
<td>30 (5.9) [26–41]</td>
<td>28.5 (9.4) [22–41]</td>
</tr>
</tbody>
</table>

All phases of the intubation were completed more quickly when using the ML to clear the airway during OIF. There were no significant differences in cardiovascular responses between the two groups.

**Conclusion(s):** The ML facilitates the location of the glottis with the fibrescope, insertion of the scope into the trachea and reduces difficulty in railroading the tracheal tube. The ML technique appears to be a useful and more familiar alternative for managing difficult intubation than the laryngeal traction plus jaw thrust technique, though two anaesthetists are required to carry it out.

**References:**

**A-251**

**Efficacy of the intubating laryngeal mask and direct laryngoscopy for airway management by inexperienced personnel**

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**Background and Goal of Study:** Establishing a patent airway is the primary aim during general anaesthesia as well as in emergency medicine. While tracheal intubation is considered the “gold standard”, it requires adequate skill to secure the airway. We compared the ability of inexperienced personnel to intubate the trachea using a laryngoscope or an intubating laryngeal mask (ILM).

**Material and Methods:** Before commencing the study, the investigator explained the theoretical use and practice of both techniques and demonstrated it on an airway management trainer manikin. 38 health workers with no intubation experience attempted tracheal intubation using in turn a laryngoscope and an ILM on the airway management trainer manikin. The variables recorded were the number of attempts to achieve correct placement and the time taken to achieve the first two adequate ventilations with both devices. Ventilation was deemed satisfactory when there was visible chest expansion.

**Results and Discussion:** Of the 38 participants, 34 (89.5%) correctly positioned the ILM on their first attempt while the other 4 were successful on their second attempt. 32 participants (84.2%) successfully intubated via the ILM on their first attempt and 6 on their second. Of the intubation attempts using direct laryngoscopy, 24 participants (63.2%) were successful on their first attempt, 10 (26.3%) on their second and 4 (10.5%) on their third attempt. The mean time for effective intubation and adequate ventilation via the ILM was 21.8 s while mean time for intubation via direct laryngoscopy was 36.2 s (p < 0.05). In the questionnaires, most participants indicated that they found tracheal intubation easier with the ILM than with direct laryngoscopy.

**Conclusions:** Taking into consideration our results it seems that the ILM is a more effective mean of airway management and tracheal intubation when used by inexperienced health workers.

**References:**

**A-253**

**A simple technique to correct malpositioning of a left-sided double-lumen tube by paradoxical fiberoptic guidance**

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**Background and Goal of Study:** Deviation of the double-lumen tube from a bronchus during differential ventilation is not unexpected, frequently causing hypoaxemia and cardiovascular instability. Since repositioning of this tube is not so easy, we designed a new, simple technique for correct re-insertion of the left-sided double-lumen tube (LSDT).

**Materials and Methods:** Patient requiring one-lung ventilation (lobectomy, partial resection and lung biopsy) were intubated using a left-sided double-lumen tube (Broncho-Cath™; Mallinckrodt Anesthesiology, St-Louis MO, USA) in Shinshu University Hospital. The correct position of the LSDT was verified by bronchoscopic inspection. In 13 patients, a secondary dislocation of the LSDT occurred. The following technique was designed:

First, we inserted a fiberoptic bronchoscope (Olympus LFTP; diameter ~ 28 mm; Olympus Optical Co Ltd, Tokyo, Japan) into the tracheal lumen without removal of LSDT. Next, this fibroscope was advanced 2–3 cm into the right bronchus. This bronchus was “blocked” by the fibroscope and we were able to re-insert the LSDT correctly into the left bronchus.

**Results and Discussion:** This technique was successful in all cases (15 re-insertions in 13 patients). Specifically, it was useful in the patients in the lateral decubitus position. The flexibility of the LSDT and of the fiberoptic bronchoscope may make re-insertion with standard technique more difficult. We saw no bronchial perforation or mucosal bleeding. Displacement of the LSDT was caused by extension of the neck (1) or by decubitus position (2). If the neck movement can be anticipated, an insertion of the LSDT more deeply is an alternative measure (3).

**Conclusion:** This technique was always successful to re-insert the LSDT into the left bronchus.

**References:**
The goal of this study was to investigate the changes (Δ) of P_{aCO2} levels during anesthesia and HFJV for the laser microsurgery on the larynx (LML).

**Material and Method:** After obtaining an approval of the local Ethics Committee, 14 ASA I–II patients were included in the study. General anesthesia in all patients was induced with alfentanil (30 mcg/kg), propofol (2 mg/kg) and mivacurium (0,15 mg/kg). After obtaining muscle relaxation, the tip of the Hunsaker jet catheter was placed about 2 cm above carina. The HFJV was then commenced (frequency – 150/min, FiO2 – 0,4, inspiration time – 40%, driving pressure – 2 bars). The arterial blood samples were taken for P_{aCO2}, P_{aO2}, S_{aO2} and pH analysis prior to the start of HFJV, at 5 and 15 min. during LML with jet ventilation and 10 min. after of LML (still jet ventilation). We calculate the average increase or decrease (mean ± standard deviation) of P_{aCO2} between 5 and 15 min. during LML (period 1) and between 15 min. during LML and 10 min. after LML (period 2). Statistical analysis was performed with Mann-Whitney U test.

**Results and Discussion:** There was significant difference in changes of the levels of P_{aCO2} (kPa) between period 1 and period 2, (0,184). There was also significant difference in pH changes between periods, (0,003) in period 1 and 0,039 in period 2, p < 0,04) respectively. We observed, especially no barotraumas. In only 3 patients endotracheal intubation was carried out (mean PaO2 133.8 ± 39.4 mmHg and mean PaCO2 42.3 ± 10.1 mmHg).

**Conclusion:** The presence of burning tissue smoke with the high concentration of CO_{2} is the serious barrier for CO_{2} elimination during laser microsurgery on the larynx with high frequency jet ventilation. Our study will be continued with special exhaust tube for the smoke.

**References:**

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**A-258**

Superimposed high frequency jet ventilation (SHFJV) for endoscopic laryngotracheal surgery, experiences with 1515 patients

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**Background and Goal:** Superimposed high-frequency jet ventilation (SHFJV), which does not require any endotracheal catheters, was developed specifically for application in laryngotracheal surgery. SHFJV uses two jet streams with different frequencies, which are simultaneously applied, in the supraglottic space, using a jet laryngoscope and a new jet ventilator.

**Patients and Methods:** Between 1990 and 2003, SHFJV was used consecutively in 1515 patients, including 158 children requiring laryngotracheal surgery. Ventilation was performed with an air/oxygen mixture and anesthetic agents. In 632 patients, arterial blood gas analyses were carried out (mean PaO2 133.8 ± 39.4 mmHg and mean PaCO2 42.3 ± 10.1 mmHg).

**Results:** In 1512 patients, adequate oxygenation and ventilation was achieved (p < 0.05). No complications due to the ventilation technique were observed, especially no barotraumas. In only 3 patients endotracheal intubation was necessary (p < 0.05). SHFJV was also successfully applied for laser surgery (n = 312). It was a safe ventilation mode without any complications such as airway fire, major hemorrhage or aspiration of debris.

**Conclusions:** SHFJV represents an enhanced ventilation mode, which, in fact, plays a pivotal role in the open ventilation of patients with laryngotracheal stenosis. It is especially indicated in cases of severe stenosis, and offers optimal conditions for the laryngotracheal surgery, including the laser surgery and stent implantation techniques.

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**A-257**

Pulmonary functions after coronary artery bypass surgery

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**Background and Goal of Study:** Coronary artery bypass graft surgery (CABG) adversely affects pulmonary function tests (PFTs). The purpose of the present study was to assess changes in pulmonary function following CABG and to identify factors that may influence these changes.

**Materials and Methods:** The subjects were 41 cardiac surgery patients, 36 men and 5 women, mean age 53 years. Vital capacity (VC), forced vital capacity (FVC), residual volume (RV), forced expiratory volume first second (FEV1), force mid expiratory flow (FEE25-75) were measured preoperatively, 1 and 12 weeks postoperatively, and radiographies were taken at the same points in time.

**Results and Discussions:** All pulmonary function measurements except the FEV1/FVC showed a significant decrease and a restrictive pattern compared with preoperative values. On the first postoperative week, the FVC decreased to 30% of the pre-operative value. The changes in FVC were not significantly related to sex (P = 0.07), smoking history (P = 0.19) or pump time (0.29). But FVC changes were related to age (P = 0.05) and Extubation time (P = 0.01). The decreases in spirometry on postoperative one week (FVC 1.95 ± 0.63; FEV1 1.45 ± 0.46 literes) were greater (p < 0.001) in the late extubation group. However, on the 3rd postoperative months, the FVC remains less than 20% below preoperative values.

**Conclusion(s):** A severe, reversible restrictive pulmonary function change follows coronary artery bypass grafting. This change affected by age and extubation time.

**References:**

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**A-258**

Lung function and prevention of respiratory disturbances at surgery concerning huge abdominal hernias

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**Background and Goal:** Acute respiratory failure due to increase of intra abdominal pressure during surgical reposision of hernia contents into abdominal compartment is frequent complication in patients with huge abdominal hernias. An excessive pain and compression of intestines additionally aggravate the postoperative course. Mortality rate achieves 20%. Perioperative estimation of a lung function and prevention of respiratory failure were the aim of this study.

**Materials and Methods:** 103 patients with huge abdominal hernias (35 men and 68 women of 25–78 years old) undergoing surgery were studied. 79 patients had morbid obesity, 29 – CAD, 66 – arterial hypertension, 31 – COPD, 7 – diabetes. The computer herniobodemometry (CHAM) was carried out in 79 patients before operation to estimate an abdominal/hernia size ratio (AHR). Forced expiratory F/V curves were analyzed in all patients before and after surgery. Combined preemptive analgesia – prolonged epidural and non steroid antiinflammatory medication along with séances of noninvasive lung ventilation and early activation was performed after surgery.

**Results and Discussion:** Patients were divided in three groups on the base of CHAM data: 1 – middle hernias 46 (58.2%) pts-AHR = 5–14%; 2 – large hernias 14 (17.7%) patients – AHR = 15–18%; 3 – huge hernias 19 (24.1%) patients-AHR > 18%. All patients of groups 2 and 3 had demonstrated restrictive lung disturbances; in 11 patients restrictive lung disturbances were combined with obstructive ones. Adaptation of abdominal wall structures was functionally tolerable only in patients with AHR < 18%. Violent trial connection of a hernia gate edges in spontaneously breathed patients with AHR > 18% and in patients with AHR > 14% associated with morbid obesity and COPD induced increase of intra abdominal pressure along with increase of inspiratory ratio (> 30–35%) the impossibility of a deep breath and performance of the test “the forced exhalation”, decrease of SpO2 (< 8–10%), nausea and desires to urinate. C rs decreased by 45–60%. Modeling parameters of abdominal compartment with predetermined muscles diastases determined on the basis of respiratory mechanics data. Mortality rate – zero.

**Conclusion:** Preoperative estimation of AHR and the control deep monitoring of respiratory mechanics during operation allowed correctly to choose the type of reconstructive intervention in patients with huge abdominal hernias and high risk of lung complications. The combination of such approach with comprehensive intensive postoperative therapy has allowed to reduce mortality to zero.

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**A-259**

Forced vital capacity (FVC): Normative data obtained in anaesthetised infants and children

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**Background and Goal of Study:** Forced deflation from total lung capacity is regarded as the gold standard for the generation of maximum expiratory
flow-volume (MEFV) curves in intubated infants. Normal data still needs to be defined in a large population of healthy children. **Materials and Methods:** We measured MEFV curves in 75 intubated children (mean [range] age = 101 [6–245] weeks, weight = 18.8 [4–23.5] kg) without lung disease undergoing elective surgery. Anaesthesia was standardised. All patients received atracurium prior to intubation with auffed endotracheal tube. Respiratory system mechanics (compliance, resistance) were measured by single-breath occlusion and MEFV curves were generated by forced deflation from total lung capacity (+40 cmH2O inspiratory pressure) using a deflation pressure of about 40 cmH2O. The lung function data were correlated to weight, height and ulna length measured by use of precision callipers.

**Results and Discussions:** The mean (SD) of all children was 1.13 (0.31) ml/cmH2O/kg for compliance, 0.055 (0.04) for resistance, 70.6 (14.6) ml/kg for FVC and 12.4 (5.7) ml/kg/s for MEF10.

**Acknowledgement:** The study was sponsored by the Department of Anaesthesia, University of Basel.

**A-261**

**Prevalence of obstructive sleep apnea syndrome (OSAS) and the influence of a premedication with flunitrazepam on the respiration during the night**

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**Background and Goal:** Obstructive sleep apnea syndrome (OSAS) is common in obese patients and frequently leads to cardiovascular diseases like arterial hypertension (AH) [1]. The prevalence of undiagnosed OSAS is not known. The study was performed to determine the prevalence of OSAS and the influence of flunitrazepam as premedication.

**Methods:** With IRB approval and written informed consent, 89 male patients without formerly diagnosed OSAS were included and distributed to three groups:

1. study group 1 (SG1): BMI ≥ 28 kg/m² and AH
2. study group 2 (SG2): BMI ≥ 28 kg/m² without AH
3. control group (CG): BMI < 28 kg/m² without AH

In the preoperative night, the patients received randomized 1 mg of flunitrazepam (F) orally or an oral placebo (P). Afterwards, sleep apnea screening was done with SomnoCheck effect® (Weinmann GmbH&Co. KG, Hamburg/Germany) during the night. From the number of the registered apneas, the AH (apnea hypopnea index = apneas and hypopneas per hour) was calculated. OSAS was defined as AH > 5/h [2].

**Results:** The prevalence of OSAS and the mean AH (±SD) are shown in the following table (n = number of patients):

<table>
<thead>
<tr>
<th>n</th>
<th>SG1-F</th>
<th>SG1-P</th>
<th>SG2-F</th>
<th>SG2-P</th>
<th>CG-F</th>
<th>CG-P</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMI (kg/m²)</td>
<td>30.6 ± 2.3</td>
<td>30.2 ± 1.9</td>
<td>9.4 ± 5.3</td>
<td>4.8 ± 1.6</td>
<td>9.9</td>
<td>7.8</td>
</tr>
<tr>
<td>Preval. (%)</td>
<td>85.7</td>
<td>84.6</td>
<td>50.1</td>
<td>44.5</td>
<td>19.4</td>
<td>13.6</td>
</tr>
<tr>
<td>AH (1/h)</td>
<td>16.1 ± 13.2</td>
<td>9.4 ± 5.3</td>
<td>5.3 ± 4.8</td>
<td>4.8 ± 1.6</td>
<td>9.9</td>
<td>7.8</td>
</tr>
</tbody>
</table>

**Conclusion:** The prevalence of OSAS in obese patients with arterial hypertension is extremely high (84.6% in SG1-P; 85.7% in SG1-F). The use of flunitrazepam seems not to lead to a significantly higher prevalence of OSAS and AH.

**References:**


**A-262**

**Comparative study of two types of anesthesia (TIVA and balanced NLA) in asthmatic patients undergoing functional endoscopic sinus surgery (FESS)**

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**Background and Goal of Study:** Objective of the study is the analysis of effect of two types of general anesthesia to peri and postoperative hemodynamic stability of asthmatic patients during FESS.

**Materials and Methods:** Clinical prospective study included 60 patients, ASA I and II, aged 35 ± 15 years, without any significant difference of sex, body height and weight. The patients were divided in two groups according to the type of anesthesia: Group N-balanced neuroleptic (NLA); Group T-total intravenous anesthesia (TIVA). The number of patients was identical in both groups (N = 30), as well as the severity of respiratory obstructive insufficiency. Premedication, which was the same for both groups, included i.m. midazolam and atropin as well as non-depolarizing muscle relaxant cis
atrium. For introduction of anesthesia, group N was administered midazolam, thiopental and alfentanil and inspired 50% N\textsubscript{2}O in O\textsubscript{2}. Group T was given propofol and alfentanil, and air mixture was inspired. The indicators of preoperative respiratory and hemodynamic stability were as follows: \text{PaO}2, \text{PaCO}_2, \text{EKG}, \text{NIBP}. Spirometry was used to measure of global respiratory function.

**Results and Discussions**: During surgery, hemodynamic stability was significantly better in group T, while there was no significant difference of respiratory stability between these groups, what was all illustrated in the following Table:

<table>
<thead>
<tr>
<th></th>
<th>NLA</th>
<th>TIVA</th>
</tr>
</thead>
<tbody>
<tr>
<td>p &lt; sd</td>
<td>91.2 ± 13.2</td>
<td>70.9 ± 10.1</td>
</tr>
<tr>
<td>\text{SaO}_2</td>
<td>99.1 ± 1.3</td>
<td>99.3 ± 1.2</td>
</tr>
<tr>
<td>\text{PaCO}_2</td>
<td>3.5 ± 0.3</td>
<td>3.5 ± 0.2</td>
</tr>
<tr>
<td>\text{FEV1}</td>
<td>92.0 ± 23.1</td>
<td>94.2 ± 21.6</td>
</tr>
<tr>
<td>\text{PaO}_2</td>
<td>11.3 ± 1.9</td>
<td>12.0 ± 1.6</td>
</tr>
</tbody>
</table>

There was highly significant difference of pressure values (NIBP) between first and second measurement, as well as the interaction (F = 30.586; p < 0.01) between time factor (F = 28.5; p < 0.01) and type of anesthesia (p < 0.01). Significantly higher pressure value was found in group N in relation to group T.

**Conclusion**: Our study verified that TIVA had indisputable advantage over balanced NLA anesthesia in asthmatic patients undergoing FESS for nasal polyposis.

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**A-264**

**Mallampati score improvement after removing total dental prosthesis**


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**Background and Goal of Study**: In the outpatient preoperative evaluation, Mallampati class in patients using dental prosthesis is usually evaluated with their artificial teeth on site. However, before tracheal intubation dental prostheses are always removed. Our hypothesis is that the Mallampati score is different when it is evaluated with or without dental prosthesis, and this study was designed to demonstrate this fact.

**Materials and Methods**: Consecutive patients admitted in our hospital with total dental prosthesis entered the study. Mallampati score was first evaluated with the dental prosthesis placed, and repeated after removing the artificial teeth. Weighted kappa coefficient was calculated to know the agreement between both measurements.

**Results and Discussions**: 120 patients (age 77 ± 8 yr, gender 57/68 M/F, BMI 26 ± 4 kg/m\textsuperscript{2}) entered the study. Kappa value was 0.28, showing “poor agreement” (1) between both measurements. Figure shows the distribution of the patients according to Mallampati class determined with or without dental prosthesis. Data in the cells indicate the number of patients for every possible combination. In only 43 patients (36%) Mallampati class was the same when evaluated with or without teeth (bold data on the diagonal). In all the remaining patients, Mallampati class was lower without teeth.

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**A-263**

**Prophylactic respiratory physiotherapy after abdominal surgery – sytematic review**

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**Background and Goal of study**: Respiratory physiotherapy is thought to prevent pulmonary complications after abdominal surgery. To test efficacy and safety of prophylactic respiratory physiotherapy after abdominal surgery.

**Material and Methods**: Comprehensive search in multiple databases and bibliographies, all languages, to 07.2004. Randomised trials testing prophylactic respiratory physiotherapy after abdominal surgery, with = 2 days' follow-up, and reporting on pulmonary outcomes. Information on study quality, physiotherapies, pulmonary outcomes, and adverse events was extracted by one investigator and cross-checked by two. For identical interventions and endpoints, data were combined using a fixed effect model, and expressed as relative risk (RR) with 95% confidence interval (CI) and number-needed-to-treat (NNT).

**Results and Discussion**: Thirty-two trials, most of poor methodological quality, tested intermittent positive pressure breathing, incentive spirometry, continuous positive airway pressure, and multiple physical therapies. Nine trials (1,364 patients) only had a no intervention control group. Deep breathing with directed cough, or intermittent positive pressure breathing on atelectasis or unspecific pulmonary complications. None reported on improved PaCO\textsubscript{2}/FiO\textsubscript{2} ratios or vital capacity values. Positive trials were more likely to report on unusually high control event rates. Twenty-three trials (2,804 patients) compared physiotherapies with each other; no conclusions could be drawn. Physiotherapies were accompanied by discomfort, claustrophobia, nose ulcer, abdominal distension, and hernia.

**Conclusion**: The evidence to support the usefulness of prophylactic respiratory physiotherapy after abdominal surgery is scarce.

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**A-265**

**Prediction and management of difficult intubation**

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**Background and Goal of Study**: Prediction and management of difficult intubation (DI) according to specific plan is the base of safe anesthesia. We worked out and evaluated system of tests for prediction of DI.

**Materials and Methods**: In 3192 cases for general surgery (GS) and 500 cases for maxillofacial surgery (MFS) probability of DI was evaluated. We used Mallampati-test alone and system of 7 tests: Mallampati + mouth opening, head flexion/deflexion, jaw advancing, thyromental distance, clinical signs (impaired maxillofacial anatomy, obesity with BMI > 0.26 or weight > 90 kg, hyperthermic type with short neck) and anamnesis (sleep apnea, difficult intubation, snoring). Predicted and actual difficulties were compared after intubation. The ASA definition of “difficult intubation” was used; all the cases with alternative methods of intubation were considered to be difficult. In cases with confirmed DI quantitative evaluation of preoperative evaluation data was performed. Mallampati-test was stratificated as: 1–2 class = 0 point, 3rd class = 1 point, 4th class = 2 points; each other test was 0 or 1 point (“no” or “yes”). We named the sum of points “Index of Difficult Intubation” – IDI. Effectiveness was evaluated by tests of specificity (Sp), sensitivity (Sen), positive predicted results (PPR) and negative predicted results (NPR). Chi-square test was used to evaluate correlation of single results of tests and result of intubations.
Results and Discussions: Occurrence of DI during GS was 0.62%, during MFS – 5.6%. Effectiveness of Mallampati-test was: Sen – 80%; Sp – 96%; PPR – 44%; NPV – 48.6%. Mallampati-test was effective for prediction of easy intubation and not often – for DI. All used test had strong correlation with results of intubation (p < 0.005). Effectiveness of DI was: Sen – 96%; Sp – 98%; PPR – 75%; NPV – 99%. When DI was 5 or more points (3.6% of patients), we used alternative methods of intubation. On DI 3–4 points (2.2% patients) actual DI was in 1.2%, on DI 1–2 points (2.8%) actual DI was in 0.8% of cases. When DI ≤ 5 points – oblige DI, on DI 3–4 points – DI is highly possible, on DI 1–2 DI is possible, on DI 0 there is no difficulties.

Conclusion(s): System of 7 tests allows to effectively predict DI, evaluation of DI allows to choose rational method of tracheal intubation.

A-266
Locoregional anesthesia of upper airways vs IV sedation in patients with prolonged postoperative intubation
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Background and Goal of Study: After maxillofacial (MFS) surgery extubation should be performed after guaranteed ability of patient to manage airways himself. IV sedation is widely used for adaptation of patient to tracheal tube, this make difficult to evaluate level of consciousness, can cause respiratory depression and prolongs ICU stay. The goal of study was to evaluate locoregional anesthesia of upper airways (LAURA) as an alternative of IV sedation in a cases of prolonged intubation postoperatively.

Materials and Methods: 147 patients (15–74 yr., ASA I–II) after reconstructive MFS needed prolonged intubation. In 1st group (n = 127) we used LAURA, in 2nd group (n = 10) we used IV sedation (midazolam, 0.06 ± 0.056 mg/kg). LAURA for awake intubation was performed by bilateral block of superior laryngeal nerve and glossopharyngeal nerve with 2% lidocaine with epinephrine 1:200 000 and transtracheal anesthesia with 4% lidocaine.

Results and Discussions: On admission to ICU or recovery room on tracheal tube traction coughing reflex was absent in 60% in 1st group and in 75% with epinephrine 1:200 000 and transtracheal anesthesia with 4% lidocaine. Of superior laryngeal nerve and glossopharyngeal nerve with 2% lidocaine LAURA, in 2nd group (n = 26) we used IV sedation (midazolam, 0.06 ± 0.056 mg/kg). LAURA for awake intubation was performed by bilateral block of superior laryngeal nerve and glossopharyngeal nerve with 2% lidocaine with epinephrine 1:200 000 and transtracheal anesthesia with 4% lidocaine. Clinical signs and length of block, changes in oxygenation and system hemodynamics, level of sedation (Ramsay) were controlled after operation, before transporting from operation room, on admission to recovery room or ICU and before extubation. Results were statistically processed (T-test).

Conclusion(s): LAURA can be rational alternative for IV sedation for patients with prolonged tracheal intubation.

A-267
Utility of lateral-view neck radiography for airway assessment
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Background and Goal of study: Preoperative preparation of potential difficulties with intubation can reduce risks associated with anesthesia, particularly in patients undergoing cervical spinal surgery. Although several clinical criteria exist for airway assessment on patients, including mouth Mallampati classification and thyromental distance, no sufficient systematic multivariate analysis has been reported. We investigated the utility of information including pharyngeal airway space, position of epiglottis and neck flexibility obtained from lateral-view neck radiography.

Materials and Methods: Subjects comprised 100 orthopedic patients who underwent cervical anterior decompression or laminectomy for cervical myelopathy or ossification of the posterior longitudinal ligament. Vertical distance between the epiglottis and retropharyngeal wall, height of the epiglottis compared to the vertebrae, and angle of the lower endplate line of C1 and C4 were evaluated from preoperative lateral-view neck radiography in the extension position.

Results and Discussions: Poor evaluation of intubation or other factors affecting tracheal intubation resulted in the exclusion of 26 subjects. Tracheal intubation was difficult in 19 patients (26%), and easy in 55 (74%). Such difficulties were detected using pharyngeal airway space (<16 mm; sensitivity, 53%; specificity, 89%; accuracy, 80%), position of epiglottis (lower than C3; sensitivity, 100%; specificity, 64%; accuracy, 73%), and neck flexibility (<25°; sensitivity, 89%; specificity, 80%). Patients displaying these factors experienced difficulty with tracheal intubation (sensitivity for 3 factors: 100%); 2 factors: 92%; 1 factor: 13%; 0 factors: 4%).

Conclusion(s): Information on pharyngeal airway space, position of epiglottis and neck flexibility from lateral-view neck radiography in the extended position could greatly facilitate airway assessment prior to anesthesia.

A-268
Anaesthesia experience improves a good ability to find out difficult airway
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Background and Goal of Study: Anaesthesiologists with long history of working experience ought to have a good ability to find out difficult airway just by looking at the patient and his face. We tried to verify this hypothesis by using the method of ranking averaged pictures of patient’s faces which were classified by the Cormack & Lehane’s grade (Cormack grade).

Materials and Methods: Patients who were scheduled to undergo general anaesthesia were involved in this study. After obtaining informed consent, pictures of the patient’s front and side face were taken by a digital camera. Patients were classified into 4 groups according to Cormack grade determined by skilled anaesthesiologists. Average pictures of the faces combined were synthesized in each Cormack grade by computer software.

Anaesthesiologists were classified into 5 groups according to their experience (1–5, 6–10, 11–15, 16–20, or over 21 years) and asked to rank the averaged face pictures to agree with Cormack grade. Disagreements between the picture’s order and its Cormack grade were scored and recorded.

The score was compared using the Kruskal–Wallis test and Mann–Whitney test among the experienced groups.

Results and Discussions: During the experimental period, there were no Cormack graded 4 patients. Twelve averaged face pictures (male front face Cormack 1–3, male side face Cormack 1–3, female front face Cormack 1–3, female side face Cormack 1–3) were synthesized.

The pictures ranked by the experienced anaesthesiologist groups were correctly ranked with the Cormack grade. However the unexperienced groups did not match correctly (p = 0.048).

Conclusion: Anaesthesiologists with experience might have an ability to find out which patient have difficult airways by just looking at their faces, as compared with unexperienced anaesthesiologists.

A-269
Ultrasound quantification of anterior soft tissue thickness fails to predict difficult laryngoscopy in obese patients
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Background and Goal of Study: Morbid obesity is associated with difficult laryngoscopy and intubation; however, the best way to predict airway difficulties remains unknown. An abundance of pretracheal soft tissue anterior to the vocal cords, as quantified by ultrasound, was a better predictor of difficult laryngoscopy than body mass index (BMI) in Israeli patients. We sought to confirm this finding in our patients.

Materials and Methods: In 64 morbidly obese patients (BMI > 35 kg/m²), we used ultrasound to quantify neck soft tissue from the skin to the anterior aspect of the trachea at the vocal cords. Thyromental distance, mouth opening, jaw movement, limited neck mobility, modified Mallampati score, abnor-
mal upper teeth, neck circumference, history of obstructive sleep apnea (OSA), BMI, age, and sex were assessed as predictors of difficult laryngoscopy.

Results and Discussions: Twenty patients were classified with difficult laryngoscopy; they were older (47 ± 9 vs. 42 ± 11 years; P = 0.048; mean ± SD) and had less soft pretracheal tissue (20.4 ± 3.0 vs. 22.3 ± 3.8 mm; P = 0.049) than did easy laryngoscopy patients. A multivariable regression model indicated that a history of OSA was the only independent predictor of difficult laryngoscopy (Odds ratio [95% CI] of 2.48 [1.03–5.96]; P = 0.042).

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Conclusion(s): We conclude that the thickness of pretracheal soft tissue at the level of the vocal cords is not a good predictor of difficult laryngoscopy in obese patients in the United States.

References:

A-270
Age related incidence and complications of difficult intubation in 25,040 general anaesthetics in a tertiary hospital
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Background: Difficult intubations carry a higher risk of morbidity and mortality. Studying its incidence and predisposing factors is essential for its prediction.

Aim: To determine the incidence of complications of difficult intubation and its relationship to age in a tertiary hospital.

Method: Data was collected prospectively from 25,040 non-cardiac anaesthetics (1994–1999). Demographic characteristics of patients and Cormack and Lehane laryngoscopic view classification, methods of management and complications were encoded using a customized database program and analyzed with SAS software.

Results: The incidence of difficult intubations was (0.96%), (14.8%) were grade 2, (59.9%) grade 3, and (25.2%) grade 4. In pediatric age group <1 year, (1%), from (1 ≤ 5) (0.95%), (from 5 ≤ 10) (0.59%) and from (10 ≤ 15) (3%) indicating decreased incidence with age. The pearsons correlation r = 0.94 and the P value (≤ 0.34). In the adult age groups (15–20 yrs) was (0.65%), (20–40 yrs) was (0.47%), (40–50 yrs) was1.38%, (50–60 yrs) was 1.85% and >60 yrs was 1.9%. Pearson correlation was positive r = 0.85 (p value = 0.023). The incidence of failed ventilation and intubations was 0.004%. The following complications were increased in difficult intubations: reversible cardiac arrest (0.8%), compared with 0.004% in easy intubations; p < 0.001 and dental injuries (2%), compared with 0.07% in easy intubations p < 0.0001). Failed ventilation and intubations was 0.004%. There was no aspiration or death.

Conclusion: Difficult intubations are infrequent (0.96%), but are associated with a higher incidence of major anaesthetic adverse outcomes. There is a negative correlation with age in pediatric group and a positive one in adult groups. Prediction of difficult intubation in the high-risk age groups would help to improve the outcome.

A-271
Does tracheal transverse diameter predict accurately the choice of double lumen tracheobronchial tube for one-lung ventilation?
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Background and Goal of Study: To make easier the choice of a left double lumen tracheobronchial tube for one lung ventilation, Brodsky proposed to assess the diameter of the left main bronchus (LBTD) with the tracheal transverse diameter (TTD): the LBTD-to-TTD ratio was consistent for men (0.75 ± 0.09) and women (0.77 ± 0.10). The aim of study was to analyse the relationship between LBTD and TTD with use of tri-dimensional chest computed tomographic scan.

Materials and Methods: 206 chest computed tomographic scans were analysed with measure of LBTD 1 cm away from the carina. A tri-dimensional correction of declination was performed. The difference between measured value (LBTD meas) and theoric value (LBTD theo) was calculated for each observation. A difference up to 1 mm was considered as significant resulting in change of 2 sizes of double lumen tube.

Results and Discussions:

Distribution of differences between measured and theoric values.
Difference between measured and predictive values with Brodsky model is up to 1 mm in 61% of men and in 59% of women (hatched columns).

References:

A-272
Edema risk of endotracheal intubation in rabbits with cessation of steroid therapy
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Background and Goal of Study: Laryngeal edema is a life threatening risk of intubation (1). Rebound edema of tissues is also a well defined complication of cessation of steroid therapies (2). We want to study if laryngeal edema increases after intubation when it is established after steroid therapy is stopped.

Materials and Methods: Thirty-six adult female New Zealand rabbits (1.8-2.8 kg) were randomly divided into six groups. We modelled chronic obstructive pulmonary disease therapy as a steroid therapy. We gave 1 mg/kg methyl prednisolone intraperitoneally to four steroid groups for ten days. Another group received 0.9 sodium chloride (SF) for ten days and last group was control group (cont) that was intubated only. Rabbits that received steroid therapy are intubated one day (st 1d), one week (st 1w), two weeks (st 2w) and a month (st 1 m) after stopping steroid therapy. Rabbits that are intubated are kept under anaesthesia for an hour. They are extubated and kept on spontaneous respiration for two hours. They are sacrificed and their larynxes are taken for histopathological examination. Percentage of cross section area of larynx lumen to their transversal diameter was measured (LBTO) and anaesthetization with use of tri-dimensional chest computed tomographic scan.

Results and Discussions: Larynx lumen of two steroid groups (st 1d, st 1w) were significantly narrower (p < 0.05) than SF and cont groups while it was not narrower in other two steroid groups statistically (p > 0.05). These results suggests that one day and one week after stopping steroid therapy may be a hazardous time for tracheal intubation.
A-273
Clinical evaluation of a new disposable airway device: The Ambu Laryngeal Mask
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Background and Goal of Study: The major interest of single use airway devices is the prevention of transmission of infectious agents. The Ambu™ Laryngeal Mask is a new disposable supraglottic airway device. It consists in a pre-angled moulded airway tube to fit the anatomical structure of the patient's throat. The goal of this prospective open study was to evaluate Ambu™ Laryngeal Mask for airway management during elective surgery.

Materials and Methods: After Ethics Committee approval and written informed consent, 60 adult patients, ASA grade 1–2, scheduled for short-lasting anaesthesia were studied. Patients with BMI >30 kg/m² or predicted difficult airway were excluded. After induction of anaesthesia, Ambu™ Laryngeal Mask (size 4 or 5) was inserted in strict accordance with the manufacturer’s recommendations. Three attempts were allowed. The proper position of the device was checked by easy bag ventilation without leak and presence of a capnogram with a plateau. The lungs were ventilated with volume-controlled ventilation. Tidal volume (VT) was set at 10 mL·kg⁻¹, the respiratory rate at 12 min⁻¹ and the inspiratory/expiratory ratio at 1:2. The fresh gas flow was set at 1.5 L·min⁻¹ (O₂/air 1/1). Success and insertion time, oropharyngeal leak pressure (OLP), peak airway pressure (PAP), per and postoperative side effects were recorded. Results given are the median (25–75%) or the mean (± SD) when data were normally distributed.

Results and Discussions: The median age, height and weight were 39.6 yr (21–63), 172 cm (155–198) and 78 kg (54–98), respectively. Insertion was successful in 59 patients (98.3%) (first attempt n = 51, second n = 6, third n = 2). The mean insertion time, OLP and PAP were 27 (±6) s, 23 (±5.8) cmH₂O and 14.3 (±3.7) cmH₂O, respectively. Neither desaturation nor gastric insufflation were noted. Occurred bloodstain was found in only two (3%) cases.

Conclusion(s): The Ambu™ Laryngeal Mask is a non-traumatic, easily inserted and efficient device to perform pressure-controlled ventilation. These results are similar to preliminary results reported for Laryngeal mask airway Unique™ or Soft Seal™ laryngeal mask (1).


A-274
The Solus: clinical evaluation of a new disposable supraglottic airway device
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Background and Goal of Study: The Solus™ Laryngeal Mask Airway (SLMA) is a new disposable supraglottic airway device. The goal of this prospective open study was to evaluate the SLMA for airway management during elective surgery.

Materials and Methods: After ethics committee approval and written informed consent, 35 patients, ASA grade 1–2, scheduled for short-lasting anaesthesia were studied. Patients with BMI >30 kg/m² or predicted difficult airway were excluded. After induction of anaesthesia, SLMA (size 3, 4 or 5) was inserted with LMA finger insertion technique. Three attempts were allowed. The proper position of the device was checked by easy bag ventilation without leak and presence of a capnogram with a plateau. The lungs were ventilated initially with volume-controlled then pressure-controlled ventilation. Tidal volume (VT) was set at 8 mL·kg⁻¹, 1·E at 1/2 and respiratory rate was set to provide 40 ± 5 mmHg ETCO₂. The fresh gas flow was set at 1.5 L·min⁻¹ (O₂/air 1/1). Success and insertion time, oropharyngeal leak pressure (OLP), peak airway pressure (PAP), per and postoperative side effects were recorded. Manual and mechanical ventilation were assessed as easy, moderate or difficult. Results are given as median (range) or mean (± SD).

Results and Discussions: The median age for weight were 23.8 yr (6–72) and 61.2 kg (30–94), respectively. Insertion was successful in 32 patients (91.4%) (first attempt n = 26, second n = 4, third n = 2). Mean insertion time, OLP and PAP were 27 (±6) s, 22.8 (±5.8) cmH₂O and 14.3 (±3.1) cmH₂O, respectively. Manual, volume and pressure-controlled ventilation were easy in 97, 84 and 100%, respectively and moderate in 3, 16 and 0% of cases. Neither desaturation nor gastric insufflation were noted. Occurred bloodstain was found in only one case.

Conclusion(s): The Solus™ Laryngeal Mask Airway is a non-traumatic, easily inserted, efficient device to perform pressure-controlled ventilation. These results are similar to preliminary results reported for Laryngeal mask airway Unique™ or Soft Seal™ laryngeal mask (1). Further comparative studies are needed to compare the SLMA with other disposable supraglottic airway devices.

Results: Incidence of gastric distension and blue dye in hypopharynx (6.1% in Group ETT; 13.7 in Group LMA; 6.7% in Group PLMA) were similar in all groups (p > 0.005). Mean $P$$_{ETCO_2}$ values were increased significantly in all groups and highest in Group PLMA (p < 0.005). Mean $PaCO_2$ values were increased significantly in all groups (p < 0.05). At the end of the pneumoperitoneum mean pH values were decreased significantly in all groups and lower in Group PLMA than Group ETT (p < 0.05).

<table>
<thead>
<tr>
<th>Group</th>
<th>ETT</th>
<th>LMA</th>
<th>PLMA</th>
</tr>
</thead>
<tbody>
<tr>
<td>$P$$_{ETCO_2}$</td>
<td>34.1 ± 37.3</td>
<td>35.6 ± 38.6</td>
<td>34.5 ± 41.8</td>
</tr>
<tr>
<td>$PaCO_2$</td>
<td>35.3 ± 39.4</td>
<td>36.5 ± 40.7</td>
<td>34.9 ± 41.3</td>
</tr>
<tr>
<td>pH</td>
<td>7.44 ± 7.39</td>
<td>7.43 ± 7.38</td>
<td>7.43 ± 7.38</td>
</tr>
</tbody>
</table>

*P* < 0.05.

Conclusion: It is concluded that gastric distension and regurgitation risks were similar and arterial blood gas tensions were in normal ranges with either airway device during laparoscopic cholecystectomy.


A-277

LaryVent and Laryngeal Mask Airway: a comparison during routine surgical procedures

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Background and Goal of Study: Reusable supraglottic airway devices have been established in clinical anesthesia for years and were previously shown to be safe and efficient (1). The purpose of the present prospective, randomised, controlled trial was to assess two disposable devices, the newly developed LaryVent™ (LV) and Laryngeal Mask Unique™ (LMA-U) in routine clinical practice.

Materials and Methods: After approval of our IRB and written informed consent was obtained, in 60 patients (ASA 1–3), undergoing minor routine surgery, standardised anaesthesia was induced (Remifentanil, 0.5 $\mu$g/kg/min; Propofol, 2 mg/kg). Patients were randomly allocated to controlled ventilation ($FI_02$, 0.4; $VT$, 7 ml/kg; respiratory rate, 10 min$^{-1}$) with the LMA-U (n = 30) or PA (n = 30). Cuff inflation was performed with 100 ml (LV) or 20 ml (LMA-U) of air. After 5 and 10 minutes of ventilation with the LMA-U or PA, $EtCO_2$, $SpO_2$, $VTe$ x and $Paw$ were recorded. Capillary blood gas samples were taken before induction of anaesthesia, and after 10 minutes of ventilation. Time of insertion and airway leak pressure (1) of each device were measured. Occurrence of gastric inflation was assessed with a stethoscope placed on the epigastrium. Patients were asked about sore-throat, dysphonia, and dysphagia 24 hours after surgery.

Results: There were no differences in demographic data between groups at baseline. Time of insertion was comparable with the LMA-U and PA (Median: 23 vs 24 sec; P = ns; failures: LMA-U 3/30 vs. PA 11/30). Blood gas samples and ventilation variables revealed sufficient ventilation and oxygenation with either device ($P < 0.05$). $PaCO_2$, $Paw$ (LMA-U, 15 ± 3 cmH$_2$O; PA, 14 ± 2 cmH$_2$O) was comparable, while airway leak pressure (LMA-U: median, 15 cmH$_2$O; range, 10 to 25 cmH$_2$O vs. PA: 22, 12 to 40) was significantly ($P < 0.05$) higher with the PA compared to the LMA-U. Post-operative sore throat and dysphagia were graded significantly ($P < 0.05$) higher with the PA than with the LMA-U. No gastric inflation occurred with either device.

Conclusions: The LMA-U and PA were proven in a clinical trial to effectively ventilate and oxygenate patients. Significantly higher failure rate and post-operative patient discomfort suggest that the PA may not be the first choice in routine clinical practice.


A-279

Comparison of new perilaryngeal airway (Cobra PLA) with laryngeal mask airway (LMA) and laryngeal tube (LT) in short surgical procedures

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Background and Goal of Study: Perilaryngeal airway (Cobra PLA) is a new supraglottic device and is an alternative to endotracheal intubation in short surgical procedures. This study was designed to evaluate new Cobra PLA and compare it with LMA and LT.

Materials and Methods: After ethical approval and patient written consent, 90 ASA I-II status, aged between 18–65 patients scheduled for short surgical procedures were included. After standard premedication patients were monitored for mean arterial pressure, heart rate and $SpO_2$. After standard anesthesia induction all patients were ventilated by mask and et-$CO_2$ pressure was monitored, inspiratory and expiratory anesthetic concentration was observed. Patients were randomly divided into three groups, to I group CobraPLA, II group LMA, III group LT was inserted by an experienced anesthesiologist. Patients were asked about sore-throat, dysphonia, and dysphagia 24 hours after surgery.

Results: There were no differences in demographic data between groups at baseline. Time of insertion was comparable with the LMA and U-Median: 24 vs 23 s; P = ns; failures: LV 10/30 vs. LMA-U 3/30. Blood gas samples and ventilation variables revealed sufficient ventilation and oxygenation with either device ($P < 0.05$). $Paw$ (LV, 14 ± 3 cmH$_2$O; LMA-U, 15 ± 3 cmH$_2$O) was comparable and airway leak pressure (LV, 37 ± 7 cmH$_2$O; LMA-U, 17 ± 5 cmH$_2$O) was significantly ($P < 0.05$) higher with the LV compared to the LMA-U. Post-operative sore throat and dysphagia were graded significantly ($P < 0.05$) higher with the LV than with the LMA-U. No gastric inflation occurred with either device.

Conclusions: Significantly higher failure rate and post-operative patient discomfort suggest that the LaryVent™ may not be the first choice in routine clinical practice.

A-280
Addition of remifentanil to etomidate to facilitate the LMA insertion conditions

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Background and Goal of Study: Etomidate as it doesn’t depress the laryngeal reflexes, it’s difficult to insert laryngeal mask airway (LMA) (1). To facilitate the LMA insertion, remifentanil addition to etomidate induction was investigated in this prospective, randomised study.

Materials and Methods: After ethics committee approval and informed consent ASA I–II, 57 unpremedicated adult patients (26–73 years) undergoing cystoscopy were recruited. The groups were: Group PF: Induction with propofol (2.5 mg/kg)1 and fentanyl (1 μg/kg), Group PR: Induction with propofol (2.5 mg/kg)1 and remifentanil loading with 0.5 μg/kg–1 min–1 for 2 min followed by 0.05 μg/kg–1 min–1. Group ER: Induction with etomidate (0.3 mg/kg)1 and remifentanil at the same dose. Anaesthesia was maintained with 2–3% sevoflurane, 50% O2 and 50% N2O. LMA was inserted by the blinded anaesthetist to assess the parameters on the table and any unwanted responses such as gagging, coughing, hicchoux, cough rigidity and limb movement. Anova test, Tukey HSD, Kouskal Wallis test, Mann Whitney U test, Pearson Chi Square test were used for statistical analysis. The results are given as percentages, 95% confidence interval.

Results and Discussions: The results are shown in the Table (*p < 0.05, **p < 0.0.5 compared to Group 1).

<table>
<thead>
<tr>
<th>Jaw opening</th>
<th>Group PF</th>
<th>Group PR</th>
<th>Group ER</th>
</tr>
</thead>
<tbody>
<tr>
<td>(open/partially open)</td>
<td>(100%/0%)*</td>
<td>(98.6%/31.3%)*</td>
<td>(65.5%/54.5%)*</td>
</tr>
<tr>
<td>Ease of LMA</td>
<td>19/0</td>
<td>15/1</td>
<td>19/0</td>
</tr>
<tr>
<td>Insertion (good/poor)</td>
<td>(100%/0%)*</td>
<td>(93.8%/3.6%)*</td>
<td>(68.2%/31.8%)*</td>
</tr>
<tr>
<td>Number of attempts (1/0/2)</td>
<td>19/0/0</td>
<td>16/0/0</td>
<td>11/10/1*</td>
</tr>
<tr>
<td>Gagging (no/yes)</td>
<td>18/1</td>
<td>14/2</td>
<td>14/1</td>
</tr>
<tr>
<td>Additional propofol</td>
<td>(94.7%/5.3%)*</td>
<td>(87.5%/12.5%)*</td>
<td>(63.6%/36.4%)*</td>
</tr>
<tr>
<td>Number of attempts (1/0/2)</td>
<td>19/0/0</td>
<td>15/1</td>
<td>12/10</td>
</tr>
<tr>
<td>Heart rate was decreased in all groups within clinical limits but it was not significant (*p &lt; 0.563).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conclusion: Co-administration of etomidate-remifentanil doesn’t facilitate the LMA insertion conditions.</td>
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</tr>
</tbody>
</table>


A-282
Comparison of LMA-Unique and Laryngeal Tube Disposable (LTD) in patients undergoing short gynaecological interventions

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Background and Goal of Study: For the reusable LMA-Classic (LMA Company) and the Laryngeal Tube (VBM MediTechnik), differences in airway leak pressure have been described by several authors (1–4). The single-use PVC products LMA-Unique (LMU) and Laryngeal Tube Disposable (LTD) are compared to test the hypothesis, that a difference in airway leak pressure can be found in these supraglottic devices as well.

Materials and Methods: After obtaining approval of the local ethics committee and patient consent, 40 women scheduled for elective short gynaecological interventions, were randomized to be ventilated with either LMU or LTD. After induction of general anaesthesia with fentanyl and propofol, airway devices were placed according to manufacturer’s instructions. Number of attempts (maximum 2), insertion time, time until first tidal volume and intraoperative tidal volumes (goal: etCO2 35 mmHg) were recorded. Airway leak pressure was measured with cuff pressures adjusted to 60 cmH2O. Devices were inspected for traces of blood after removal. Patients were questioned for postoperative complaints.

Results and Discussions: 30 patients were ventilated with ALM or LMC. Demographic data as well as, BMI, baseline heart rate, blood pressure and peripheral oxygen saturation were comparable for both groups. Insertion was successful in all patients (first attempt LMC 30, ALM 28).

Time until first tidal volume for ALM and LMC was 15.6 ± 4.4 and 15.5 ± 4.9 seconds. Tidal volumes were 8.1 and 8.0 ml kg–1 for ALM and LMC with resulting peak airway pressures of 14.5 and 14.1 cmH2O. Airway leak pressures were comparably high: 25.6 ± 5.2 cmH2O for ALM and 26.5 ± 6.5 cmH2O for LMC. Traces of blood were found in 6 devices in the LMC group and in 3 devices in the ALM group. Mild complaints (soar throat, VAS 2 on a scale of 1 to 10) were stated in the recovery room and after 24 hours by 2 patients in the LMC group and 1 patient in the ALM group.

Conclusion(s): In patients with reduced cervical spine mobility simulated by an extraction collar, a patent airway can be established rapidly with both LMA-Classic and Ambu Laryngeal Mask. Ventilation parameters, success rates and airway seal are comparable, postoperative complaints are infrequent.

A-283
Prospective comparison of Ambu Laryngeal Mask and LMA-Classic in patients with immobilized cervical spine

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Background and Goal of Study: LMA-Classic (LMA, LMA Company) and the single-use Ambu Laryngeal Mask (ALM, Ambu) are compared for ventilation in patients with simulated impaired cervical spine mobility. Ease of insertion and quality of airway seal are assessed in a prospective clinical trial.

Materials and Methods: After approval of the local ethics committee and written consent, 60 patients scheduled for elective ambulatory interventions were randomized to be ventilated with either LMC or ALM. Following standardization of induction of general anaesthesia with fentanyl and propofol and instrumentation of the cervical spine with an extrication collar (Ambu Perfit ACE), direct laryngoscopy was performed and view was graded using the Cormack and Lehane classification. Airway devices were placed according to manufacturer’s instructions. Number of attempts (maximum 2), time until first tidal volume and intraoperative tidal volumes (goal: etCO2 of 35 mmHg) were recorded. Airway leak pressure was measured with cuff pressures adjusted to 60 cmH2O. Devices were inspected for traces of blood after removal. Patients were questioned for postoperative complaints.

Results and Discussions: 30 patients were ventilated with ALM or LMC. Demographic data as well as, BMI, baseline heart rate, blood pressure and peripheral oxygen saturation were comparable for both groups. Insertion was successful in all patients (first attempt LMC 30, ALM 28).

Time until first tidal volume for ALM and LMC was 15.6 ± 4.4 and 15.5 ± 4.9 seconds. Tidal volumes were 8.1 and 8.0 ml kg–1 for ALM and LMC with resulting peak airway pressures of 14.5 and 14.1 cmH2O. Airway leak pressures were comparably high: 25.6 ± 5.2 cmH2O for ALM and 26.5 ± 6.5 cmH2O for LMC. Traces of blood were found in 6 devices in the LMC group and in 3 devices in the ALM group. Mild complaints (soar throat, VAS 2 on a scale of 1 to 10) were stated in the recovery room and after 24 hours by 2 patients in the LMC group and 1 patient in the ALM group.

Conclusion(s): In patients with reduced cervical spine mobility simulated by an extraction collar, a patent airway can be established rapidly with both LMA-Classic and Ambu Laryngeal Mask. Ventilation parameters, success rates and airway seal are comparable, postoperative complaints are infrequent.

Tissue can preserve red blood cells in stored blood preparations

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Background and Goal of the Study: In stored blood preparations, hemolysis increases according to the duration of the storage. To inhibit hemolysis, various solutions have been investigated1. In the present study, the effects of an electric field, which is used to keep freshness of the food in the freezer, on hemolysis in the stored blood preparations were investigated.

Materials and Methods: Fifteen packs of 2-day-old red blood cell concentrates (CRC) in 400 ml each of mannitol, adenine, glucose, phosphate, and citrate (MAP-CRC) were obtained from the Japan Red Cross Society. Each preparation was divided into 4 packs of equal amount and kept in a refrigerator at 4 °C exposed to 0, 500, 1500 or 3000 V electric field for 30 days. Serum

Transfusion and haemostasis
Cry GEL administration of prophylactic LMWH. No differences were observed among 500, 1500 and 3000 V. The pH in 0 V was significantly higher than 500 V. Exposing to the electric field during storage of MAP-CRC could decrease hemolysis in the preparation, while no voltage dependency was observed. Considering the pH decrease, 500 V might be the choice, though the life span of the transfused red blood cells and other effects on human should be investigated before its clinical application. **Conclusions:** To keep MAP-CRC in the electric field could decrease hemolysis in the preparation during storage.

**Reference:**

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**A-284**

Fluids and coagulation in lower limb arthroplasty

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Department of Anaesthesia, Groote Schuur Hospital Cape Town, South Africa

**Background and Goal of Study:** A prospective, randomized clinical trial to investigate whether the choice of perioperative fluid affected the procoagulant effect of haemodilution, or perioperative coagulation.

**Materials and Methods:** After Ethics approval and with informed consent, 60 patients presenting for hip or knee arthroplasties were randomized into 3 groups of fluid therapy viz. crystalloid, gelatin or starch. All patients received LMWH 12 hours before surgery. Exclusions: Known abnormality of the coagulation system, haemoglobin < 100 g/l. Patients were randomized into 3 groups or from control after fluid loading. All groups became hypercoagulable at the end of surgery and at 24 hours as evidenced by shortened r and k times after induction of anaesthesia. Exclusions: Known abnormality of the coagulation system, haemoglobin < 100 g/l. Patients were randomized into 3 groups or from control after fluid loading. All groups became hypercoagulable at the end of surgery and at 24 hours as evidenced by shortened r and k times after induction of anaesthesia.

**Results and Discussions:** There were no significant differences between groups or from control after fluid loading. All groups became hypercoagulable at the end of surgery and at 24 hours as evidenced by shortened r and k times (Fig. 1) and increased α angles. This study did not confirm a previous study\(^1\) that enhanced perioperative coagulation was triggered by rapid crystalloid haemodilution. However this effect may have been attenuated by the administration of prophylactic LMWH.

**Figure 1.** k-time

**Conclusion:** Surgery itself had a far greater effect on coagulation than the type of fluid used in this study.

**Reference:**

**Acknowledgements:** Avenits contributed to the costs of the investigation.

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**A-285**

Increased blood loss in portal thrombosis does not affect outcome after liver transplantation

A. Camps, A. Mora, M. de Nadal, C. Bosch, A. Escartín, C. Cortés

Department of Anaesthesiology, Vall d’Hebron University Hospital, Barcelona, Spain

**Background and Goal of Study:** Portal thrombosis (PT) in orthotopic liver transplantation (OLT) is a contingency that may increase surgical difficulty and patient morbidity and mortality. Recent data with new surgical technique suggest that favourable results may be achieved (1,2). The aim of our study was to analyse intra and postoperative complications of patients with PT undergoing OLT.

**Materials and Methods:** A two-year’s period retrospective study was performed in patients undergoing OLT. They were distributed in group 1 (no thrombosis), group 2 (partial PT) and group 3 (total PT). Piggy-back with temporal portocava shunt was performed in all patients. Thrombectomy and portal end to end anastomosis were performed in patients with PT. We recorded duration of surgery, total blood loss, packet red blood cells (PRBC), fresh frozen plasma (FFP) and platelets transfused, ICU and hospitalization stay and 6 month mortality. For statistical analysis Kruskal-Wallis and χ\(^2\) tests were used. Descriptive statistics were expressed in median and interquartile range (IQR).

**Results and Discussions:** 90 patients were included, 13 of them (14%) had total PT and 11 patients (12%) had a partial PT.

<table>
<thead>
<tr>
<th>Group</th>
<th>Patients (n = 90)</th>
<th>Duration of surgery (min)</th>
<th>Blood loss (L)</th>
<th>PRBCs (units)</th>
<th>FFP (units)</th>
<th>Platelets (units)</th>
<th>ICU stay (days)</th>
<th>Hospital stay (days)</th>
<th>6 month mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 1</td>
<td>66</td>
<td>365 (112)</td>
<td>3.4 (3.3)</td>
<td>5 (6)</td>
<td>7 (4.5)</td>
<td>5 (10)</td>
<td>6 (5)</td>
<td>19 (15)</td>
<td>5 (8)%</td>
</tr>
<tr>
<td>Group 2</td>
<td>11</td>
<td>320 (75)</td>
<td>2.7 (3.7)</td>
<td>4 (6)</td>
<td>6 (6)</td>
<td>6 (10)</td>
<td>5 (6)</td>
<td>20 (10)</td>
<td>0%</td>
</tr>
<tr>
<td>Group 3</td>
<td>13</td>
<td>500 (127)*</td>
<td>6.9 (4.1)*</td>
<td>10 (9)*</td>
<td>10 (3)*</td>
<td>10 (5)*</td>
<td>6 (13)</td>
<td>19 (16)</td>
<td>2 (15)%</td>
</tr>
</tbody>
</table>

\(^* p < 0.05\)

**Conclusions:** Patients with total PT had longer duration of surgery and significant increase in total blood loss and transfusion than patients with partial or no PT. There were no difference in ICU, hospital stay and 6 month mortality.

**References:**

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**A-286**

Low-frequency hemoviscoelastography in monitoring coagulation disorders after abdominal surgery for cancer

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Department of Anesthesiology and Intensive Care, Odessa Medical University, Marine Central Hospital, Odessa, Ukraine

**Background and Goal of Study:** Venous thromboembolism is one of the most common complications in cancer patients and may be due to the hypercoagulable state of malignancy and to it’s surgical treatment.

**Materials and Methods:** Patients undergoing planned curative open surgery for abdominal cancer received MEDNORD (Ukraine Coanalyser) analysis (HVG), a viscoelastic test, measures clot formation and includes information on the cellular as well as the plasmatic coagulation system. We examined the efficacy of a variety of coagulation tests. A complete coagulation screen, activated clotting time (ACT), thromboelastography (TEG) and haemoviscoelastography (HVG) were performed before surgery, at the end of surgery, and on postoperative days 1, 2, 3, and 7; they were analyzed for the reaction time and the maximal amplitude (MA).

**Results and Discussions:** We calculated the elastic shear modulus of standard MA (Gt) and HVG MA (GH), which reflect total clot strength and procoagulatory protein component, respectively. The difference was an estimate of the platelet component (Gp). There was a 14% perioperative increase of standard MA, corresponding to a 48% increase of Gt (P < 0.05) and an 80%–86% contribution of the calculated Gp to Gt. We conclude that the serial standard thromboelastography and HVG viscoelastic test may reveal the independent contribution of platelets and procoagulatory proteins to clot strength. Using multiple linear regression, all coagulation, TEG and HVG variabilities were used to model postoperative hypercoagulation. However, 3 components of the routine coagulation assay, including bleeding time, prothrombin time and platelet count could be modeled to show an 80%–86% contribution of platelets to postoperative hypercoagulability (P < 0.01). We conclude that all components of the HVG test reflect postoperative coagulopathies, these results suggest that it may be useful in determining the coagulation status of cancer patients perioperatively.

**Conclusion:** Postoperative hypercoagulability, occurring for at least 1 week after major cancer abdominal surgery, may be demonstrated HVG viscoelastotest. This hypercoagulability is not reflected completely by standard coagulation monitoring and TEG HVG viscoelastotest provides a fast and easy to perform bedside test to quantify in vitro hemocoagulation.

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A-287

Novel polyanionic starches: pharmacokinetics and effect on blood coagulation

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Background and Goal of Study: Linkage of carboxy-methyl (CM) residues to the glucose units of starch results in CM starch (CMS) – and when combined with hydroxyethylthiolate – in CM-hydroxyethyl (HE) starch (CM-HES). These polyanionic starches are more hydrophilic than conventional HES and might be promising alternatives as plasma substitutes. The goal of this study was to investigate the pharmacokinetics of these novel starches and to study their impact on blood coagulation.

Materials and Methods: This trial was conducted as a randomized controlled in vivo study in 30 pigs (40 ± 5 kg). After infusion of 20 ml/kg of HES (130/0.4) or CMS or CM-HES (6% each) over 30 minutes, serial blood samples were obtained over 20 hours. Plasma concentration was determined and blood coagulation was assessed by Thromboelastograph® (TEG®) analysis and plasma coagulation assays, Pharmacokinetic (PK)-pharmacodynamic (PD) analysis was performed based on a two-compartment model, using a linear model relating predicted concentration (PK) to observed effects. PK-PD parameters were compared by one-way ANOVA followed by Scheffé’s multiple comparisons test.

Results: Data are given as mean (SD).

Pharmacokinetic parameters:

<table>
<thead>
<tr>
<th>Parameter</th>
<th>HES</th>
<th>CMS</th>
<th>CM-HES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Area under the curve (min·g/L)</td>
<td>442 (94)</td>
<td>2959* (287)</td>
<td>2469* (283)</td>
</tr>
<tr>
<td>Terminal half-life (min)</td>
<td>185 (117)</td>
<td>525* (75)</td>
<td>561* (78)</td>
</tr>
<tr>
<td>Maximal concentration (g/L)</td>
<td>4.0 (0.5)</td>
<td>8.0* (0.6)</td>
<td>6.6* (0.4)</td>
</tr>
<tr>
<td>Central distribution volume (L)</td>
<td>9.1 (1.4)</td>
<td>5.2* (0.6)</td>
<td>6.5* (0.7)</td>
</tr>
<tr>
<td>Clearance (L/min)</td>
<td>0.115 (0.032)</td>
<td>0.016* (0.001)</td>
<td>0.019* (0.003)</td>
</tr>
<tr>
<td>Molar substitution with CMS</td>
<td>0.42 ± 0.3</td>
<td>0.34 ± 0.06</td>
<td></td>
</tr>
<tr>
<td>Molar substitution with HE</td>
<td>0.34 ± 0.06</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Pharmacodynamic parameters:

<table>
<thead>
<tr>
<th>Parameter</th>
<th>HES</th>
<th>CMS</th>
<th>CM-HES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prothrombin time (s)</td>
<td>10.2 (1.5)</td>
<td>12.7* (1.5)</td>
<td></td>
</tr>
<tr>
<td>Maximal amplitude (g/L)</td>
<td>1.12* (0.29)</td>
<td>1.11* (0.11)</td>
<td></td>
</tr>
<tr>
<td>Molar substitution with CMS</td>
<td>0.01 (0.14)</td>
<td>0.12* (0.15)</td>
<td></td>
</tr>
<tr>
<td>Molar substitution with HE</td>
<td>0.12* (0.15)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antigenic vWF level (g/L)</td>
<td>1.88 (1.67)</td>
<td>1.11* (0.11)</td>
<td></td>
</tr>
</tbody>
</table>

Postoperative shivering was rated 0–3 (0: none, 1: mild, 2: moderate, 3: severe).

Results and Discussions: The two groups presented equal demographic data, type and duration of operation, anaesthetic management and environmental conditions. There was no significant difference in the rate of mean temperature fall during the first 30 min [rate (prewarmed) = −0.78°C/L vs. rate (device) = −0.64°C/L]. Correlation coeff. ≥ 0.99 for each. Thereafter, in the device group, mean temperature ceased to fall over the next 15 min, and remained almost constant until 100 min [rate (30–100 min) = −0.077°C/L, CC = −0.85]. At 100 min, it even turned increasing [rate (100–180 min) = −0.15°C/L, CC = −0.99]. In contrast, mean temperature continued to decrease in the group of the prewarmed fluids [rate (30–180 min) = −0.36°C/L, CC = −0.95]. The difference of mean temperature between groups was significant at 60 min [dev. (35,5°C) vs. dev. 35,5°C, p < 0.05] and increased as time passed (mean Temp at 180 min: 36,2 vs. 34,7°C). Postoperative shivering was less in the device group [median = 0, max shivering = 2 in 2/15 patients] than in the group of the prewarmed fluids [median = 1, max shiv., 3 in 4/15 patients, while 7/15 patients of this group presented shivering 2 or greater].

Conclusion(s): Continuous warming at a constant temperature of intraoperatively infused fluids, by means of a warming device, maintains temperature significantly better and results in significantly less postoperative shivering compared to merely prewarming them.

A-289

Effects of gelatin solutions on polymorphonuclear cells

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Background and Goal of Study: Physicochemical characteristics of colloid determine their side effects on platelets (1,2). The goal of the present experiments was to compare various gelatin solutions on their side effect on polymorphonuclear cell (PMN) function.

Materials and Methods: After IRB approval and informed consent were obtained, citrated whole blood from 9 healthy volunteers was haemodiluted in vitro (6%, 40%) with oxypolygelatin (Gelifusin®, Braun, Austria, Maria Enzersdorf, Austria), modified gelatin (Gelifundol®, Biotest Pharmaeutika, Vienna, Austria), poly-geline (Haeacess®, Aventis Pharma, Vienna, Austria), and normal saline (Braun 0.9%, Braun, Austria, Maria Enzersdorf, Austria). An unblinded sample served as a control. Expression of Mac-1 receptor fragment CD11b was evaluated as a marker for PMN activation using the monoclonal antibodies anti-CD11b and anti-CD45. Expression of CD11b and anti-CD45. Expression of CD11b was analyzed with and without agonist-stimulation using N-formyl-Met-Leu-Phe (fMLP; 100 nM). A lyse-wash procedure was performed before flow cytometric analysis using FACSColor™ and CellQuestPro™ software (Becton Dickinson Immunocytometry Systems, San Jose, USA). Statistical analysis: one-way ANOVA (P < 0.05).

Results and Discussions: Oxypolygelatin and modified gelatin had no effect, whereas polygeline significantly increased CD11b expression after 40% haemodilution in both resting and fMLP-activated PMN when compared to controls.

Conclusion(s): Our results indicate that structural characteristics of gelatin molecules modulate their influence on PMN function. Oxypolygelatin and modified gelatin seems to exert no relevant side effect on the inflammatory response even at 40% haemodilution. The PMN-activating effect of polyge-line may, at least in part, be induced indirectly by platelet stimulation (2) and platelet–PMN interaction.

References:

A-291

Comparison of perioperative volume requirements of HES 130/0.42 and HES 200/0.5 in major urological surgery

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Background and Goal of Study: The effectiveness and tolerability of hydroxyethyl starch formulations depends mostly on the mean molecular weight and the degree of molar substitution. Because of this different volume effects could result. We compared a new HES 130/0.42 formulation (Venofundin®, B. Braun Melsungen AG, Germany) with an established HES
Materials and Methods: After approval of the local ethics committee we investigated in a prospective, randomized double-blinded clinical trial 100 adult patients scheduled for elective major urological surgery with expected large volume requirements. The study fluids were administered according to patients’ individual needs to sustain adequate haemodynamics from induction of anaesthesia until 24:00 h on the day of surgery. Infusion trigger were mean arterial pressure, central venous pressure, heart rate, or other clinical reasons. The required volume of study medication served as primary endpoint.

Results and Discussion: There were no differences in demographic and baseline characteristics between the groups. In both groups intraoperatively and during ICU stay equivalent volumes were administered to maintain or achieve haemodynamic stability (OP: HES 130/0.42: 1150 ± 574 ml; HES 200/0.5: 1070 ± 572 ml, p = 0.0002; ICU: HES 130/0.42: 1390 ± 955 ml; HES 200/0.5: 1245 ± 715 ml [Mean ± SD] p = 0.0196). Course and values of haemodynamic parameters between groups were comparable. There was no difference in total fluid balance. Routine chemistry and blood coagulation did not vary considerably. Over the entire observation period no serious adverse event occurred. In group HES200/0.5 intraoperatively red blood cells were administered more frequently (HES130/0.42: 4 patients; HES200/0.5: 11 patients; p = 0.0499).

Conclusions: The new HES 130/0.42 is equivalent to HES 200/0.5 with regard to volume requirements, safety and tolerability during surgery and ICU stay. The reason for the significant higher transfusion rate in group HES 200/0.5 cannot be explained by the study results.

A-293
Substantial donor red cell transfusion reduction by a combination of blood saving techniques
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Department of Anaesthesiology and Intensive Care, Antonius Hospital, Snejek, The Netherlands

Background and Goal of Study: Until 1999 no special blood saving techniques were used in our 300 bed general hospital, apart from loco-regional anaesthesia techniques. Realising the risks of donor blood transfusions, a blood transfusion reduction programme was started.

Materials and Methods: Introduction of the following blood saving measures and techniques:

- 2000: The so-called 4-5-6 transfusion protocol;1
- 2000: Active patient temperature control, aiming at a perioperative temperature loss less than 1°C;
- 2000: Surgical damage-control strategy;
- 2000: Perioperative and postoperative cell saving in all major surgery (hip/knee/vascular/trauma);
- 2001: Introduction symposium on the subject of blood saving techniques to increase awareness;
- 2003: 4-week preoperative epoetin alfa treatment in total hip/knee surgery for patients with Hb 10–13 g/dl at preoperative screening visit.

Results and Discussions: Both in overall hospital and in total hip and knee replacement surgery allogenic transfusion needs decreased considerably from the introduction of the first measures onward, despite increasing operation figures (see Table). Particularly in total hip and knee replacements the effects are clear, changing from 2.0 units per patient in 1999 to 0.4 units in 2003.

<table>
<thead>
<tr>
<th>Year</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003 ( prognosis)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery patients (n)</td>
<td>6473</td>
<td>7116</td>
<td>7509</td>
<td>7972</td>
<td>8837</td>
</tr>
<tr>
<td>RBC use (units)</td>
<td>3883</td>
<td>3214</td>
<td>2550</td>
<td>2839</td>
<td>2384</td>
</tr>
<tr>
<td>Total hip and knee replacements only</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients (n)</td>
<td>286</td>
<td>308</td>
<td>322</td>
<td>389</td>
<td>434</td>
</tr>
<tr>
<td>RBC use (units)</td>
<td>571</td>
<td>358</td>
<td>322</td>
<td>369</td>
<td>184</td>
</tr>
</tbody>
</table>

Conclusion: Combination of blood management measures can induce a huge allogenic transfusion reduction.

References:

A-294
Is the postoperative drained blood a good monitor for estimating the total blood loss following knee arthroplasty?
S. Bermejo, J. Garcia, S. Sánchez, J. Vallés, I. Ramos, F. Escolano
Department of Anaesthesiology, Hospital del Mar-Esperança, Barcelona, Spain

Background and Goal of Study: Although a great percentage of the total postoperative bleeding corresponds to a hidden blood loss in the tissues and joints,2,6,13,14 visible blood from the drainage is considered the gold standard for monitoring blood loss after a knee arthroplasty. Only one study was not able to find a consistent relationship between the total blood loss and postoperative drained blood.7 The aim of our study was to assess the usefulness of a postoperative drainage as a monitor of bleeding following a knee arthroplasty.

Materials and Methods: Fifty patients undergoing unilateral knee arthroplasty from March to November 2004, were prospectively followed until the fourth postoperatively day. Drained red blood cell (RBC) loss was assessed by multiplying the visible blood volume by an haematocrit (Hct) of 30% from a pilot study. Total RBC loss was calculated by multiplying the patient blood volume (PBV) by the difference between the preoperative and fourth-day postoperative Hct, and compensated with the volume of RBC transfused; [PBV × (Hct0 – Hct4th) + RBC transfused]. Hidden RBC loss was determined by subtracting the visible RBC loss from the total RBC loss. Regression analysis was performed to assess the relationship between the total RBC loss and drained RBC loss.

Results and Discussions: The average age of the fifty ASA 2 patients was 72 ± 7 years. Nearly all the procedures were performed under intradural anaesthesia. Cemented technique and tourniquet were used in all cases. The mean total RBC loss was 615 ± 197 ml. The mean drained RBC loss was 206 ± 113 ml, and mean hidden RBC loss was 414 ± 194 ml. Thus the hidden loss was 67% of the total blood loss. Regression analysis showed a poor correlation coefficient between the total RBC loss and visible RBC loss (r = 0.31, p < 0.03).

Conclusions: After knee arthroplasty, the total RBC loss can not be estimated by the visible blood from drainage probably due to the hidden RBC loss (67% of the total blood loss).

References:

A-295
Correct assessment of blood loss and haemoglobin levels for good postoperative management after knee arthroplasty
J. García, S. Bermejo, S. Sánchez, J. Vallés, L. Puig, F. Escolano
Department of Anaesthesiology, Hospital del Mar, Barcelona, Spain

Background and Goal of Study: Major blood loss from drainage occurs during the first 3–6 hours after knee arthroplasty.1 The drop in haemoglobin (Hb) is not only explained by drained blood loss, but also by the hidden blood loss in the tissues and joint.4,5 The objectives of this study were to determine the distribution of blood loss and the postoperative Hb which could better estimate the total blood loss during hospitalisation.

Materials and Methods: Fifty patients undergoing unilateral knee arthroplasty from March to November 2004 were prospectively followed until the fourth postoperative day. Baseline and postoperative Hb levels at 3–6 hours, 24 hours and the fourth day were recorded. Drained red blood cell (RBC) loss was assessed by multiplying the visible blood volume by an haematocrit (Hct) of 30% from a pilot study. Total RBC loss was calculated by multiplying the patient blood volume (PBV) by the difference between the preoperative and fourth postoperative Hct, and compensated with the RBC mass transfused; [PBV × (Hct0 – Hct4th) + RBC transfused]. Hidden RBC loss was determined by subtracting the visible RBC loss from the total RBC loss.

Results: The average age of the fifty ASA 2 patients was 72 ± 7 years and 66% of them were women. Nearly all the procedures were performed under intradural anaesthesia. Cemented technique and tourniquet were used in all cases. The mean total RBC loss was 615 ± 197 ml. The mean drained RBC loss was 206 ± 113 ml, and mean hidden RBC loss was 414 ± 194 ml. Thus the hidden loss was 67% of the total blood loss.

Hb values are shown in the Table (g/dL, mean ± SD):

<table>
<thead>
<tr>
<th></th>
<th>3–6 h</th>
<th>24 h</th>
<th>4th day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hb</td>
<td>13.9 ± 1.2</td>
<td>11.3 ± 1.6</td>
<td>10.2 ± 1.3</td>
</tr>
</tbody>
</table>

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Conclusions: Postoperative haemoglobin at 24 hours is a proper indicator for estimating the total RBC loss after knee arthroplasty. The 1.1 g/dl fall in Hb between 3–6 and 24 hours, suggests an inappropriate reposition of fluids derived from the unknown hidden blood loss (2-fold drained RBC loss).

References:

A-296
Preoperative haemoglobin optimization in total knee arthroplasty
A. Rodríguez-Pont, C. Díaz-Espallardo, C. Coillés-Calvet, I. Roig-Martínez Department of Anaesthesiology and Critical Care, Hospital de Sabadell, Sabadell, Spain

Background and Goal of Study: Interdisciplinary coordination is necessary for patient’s preoperative optimization, going to be submitted to a potential bleeding surgery. One of the most important predictive transfusion factors is preoperative haemoglobin (Hb) (1). The aim of our study is to evaluate if preoperative haemoglobin optimization reduces transfusional index in patients undergoing total knee arthroplasty.

Materials and Methods: The study was approved by the Ethical Committee of the Institution. We included 353 patients. Group 1 (n = 105) without Hb optimization. Group 2 (n = 248) the haemoglobin was optimized. Patients with level of Hb < 13 g/dl were studied by the Department of Haematology to determine what treatment would be necessary: oral iron (Fe) ± epoetin alfa (EPO). The data collected were: demographics, anaesthesia risk, Hb levels and transfusion index.

Student T and Chi squared tests were used for statistical analysis.

Results:

<table>
<thead>
<tr>
<th>Transfusion</th>
<th>Fe</th>
<th>EPO + Fe</th>
<th>Hb i</th>
<th>Hb p</th>
<th>Hb d</th>
</tr>
</thead>
<tbody>
<tr>
<td>G 1 (n = 105)</td>
<td>16 (15.2%)</td>
<td>–</td>
<td>13.6*</td>
<td>13.6*</td>
<td>9.1*</td>
</tr>
<tr>
<td>G 2 (n = 248)</td>
<td>11 (4.4%)</td>
<td>51 22</td>
<td>13.7*</td>
<td>14.1*</td>
<td>10*</td>
</tr>
</tbody>
</table>

Hb: haemoglobin, *media, EPO: epoetin alfa, Fe: oral iron.
Hb i: initial, Hb p: post-treatment, Hb d: discharge.

Conclusions: Preoperative Hb patient optimization leads us to reduce transfusion. Ferritin and plasma iron levels determination in preoperative laboratory tests are necessary to optimize Hb and also to reduce transfusion index. EPO administration has been necessary in only 22 patients.


A-297
A new and less invasive approach for the management of blood volume loss/restitucion during major trauma surgery
G. Solares, M. Salmones, J.M. Rabanal, I. Ruiz, M.A. Alonso Department of Anestesia y Trauma, Hospital Universitario Valdecilla, Santander, Spain

Background and Goal of Study: We have shown in both man and animal models that cardiac filling pressures are equivocal monitors of acute blood loss and its restitution (1,2). We propose a model based on three parameters that cardiac filling pressures are equivocal monitors of acute blood loss and its restitution (1,2). We propose a model based on three parameters.

Materials and Methods: After institutional approval, 12 major trauma surgical patients were studied. Monitoring consisted in MAP, HR, CVP and continuous ScvO2 by means of a central fiberoptic catheter (Edwards preSep), nCl was continuously measured by an esophageal “ODM” Doppler probe (Abbott lab). The changes in HR, MAP, CVP, ScvO2 and nCl were recorded every 15 minutes, and blood samples for Hb/Hht levels were taken hourly. Blood volume restitution was accomplished by the maintenance of a CVP > 5 mmHg, nCl > 2.5 min/m² and ScvO2 > 70 with the infusion of crystalloid/colloid solutions. Allogeneic blood transfusions were administered when Hb < 9 g/dl, Statistical analysis was performed using ANOVA and linear regression analysis.

Results and Discussions: Mean age = 47 ± 19 yrs; weight = 75 ± 13 Kg; height = 172 ± 10 cm. There was a negative correlation between CI vs Hb (r = 0.41; p = 0.01), but none between CI vs EPO and/or ScvO2 values.

Conclusions: Our data suggests that a model based on a pressure, CVP, a volume, nCl, and a parameter that assesses tissue oxygenation, ScvO2 may accomplish the needs for a correct blood volume status during major surgery. It is important to note, that, this model avoids the use of a PA catheter, since ScvO2 is a valid alternative to SvO2 for such approach (1,2).


A-298
Controlled low central venous pressure and its effect on blood loss in hepatic resection
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Background and Goal of Study: Hepatic resection results in significant morbidity and mortality related to intraoperative blood loss. Any strategy to reduce blood loss and blood transfusion would be of benefit to the patient. This study aims to assess the influence of central venous pressure (CVP) level on intraoperative blood loss in hepatic parenchymal transection.

Materials and Methods: This is a prospective, randomized study, that took place in the operative theater, as approved by the ethics committee. The study enrolled 40 consecutive patients ASA I-III, who underwent hepatectomy. All patients received general anesthesia with isoflurane, fentanyl, atracurium as required. We monitored invasive arterial blood pressure and central venous pressure (radial artery, internal jugular vein). The patients were assigned to two groups; the first group L1 = 20 patients who had their CVP level maintained at 0–6 mmHg through the liver resection procedure and the second group L2 = 20 patients in whom the CVP level was above 8–10 mmHg. Both groups had blood loss monitored (suction systems, compresses). The data underwent statistical analysis: average, standard deviation, Student’s test.

Results and Discussions:

<table>
<thead>
<tr>
<th>Group</th>
<th>Average bleeding [ml]</th>
<th>Stddev [ml]</th>
</tr>
</thead>
<tbody>
<tr>
<td>LT</td>
<td>1059</td>
<td>± 853,38</td>
</tr>
<tr>
<td>L2</td>
<td>1790</td>
<td>± 1366,38</td>
</tr>
</tbody>
</table>

*p < 0.05.

The patients who had the CVP maintained between 0–6 mmHg had a lower average blood loss.

Conclusion(s): Maintaining a low CVP is a good tool in reducing blood loss intraoperatively but not enough, losses being still higher than those in literature references.


A-299
Perioperative erythropoietin administration in patients undergoing radical retropubic prostatectomy
A. Dimakopoulou, K. Doumas, D. Ablianitis, A. Ioakimidou, J. Atsalakis Department of Anesthesiology, General Peripheral Hospital of Athens, Athens, Greece

Background and Goal of study: The aim of this study was to investigate the effect of recombinant human erythropoietin (r-HuEPO) administration on perioperative haemoglobin concentrations and on the number of blood transfusions in patients undergoing radical prostatectomy.

Materials and Methods: In this double-blind placebo – controlled study 30 patients received subcutaneous r-HuEPO in a dose of 600 IU/kg body weight plus iron supplementation with 300 mg ferrous sulphate orally beginning on the preoperative day 10 and 30 patients received placebo medication iron (control group). The patients received erythropoietin on preoperative day 10,7 and 4 provided their baseline haemoglobin value level 8,5–13 g/dl. Intraoperative blood loss was estimated by the amount of blood collected in

Control | Low Hb level | End surgery |
<table>
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</thead>
<tbody>
<tr>
<td>CVP mmHg 9 ± 3</td>
<td>9 ± 4</td>
<td>9 ± 5</td>
</tr>
<tr>
<td>nCl /min/m² 2.69 ± .7</td>
<td>3.35 ± 0.9</td>
<td>3.45 ± 0.9</td>
</tr>
<tr>
<td>ScvO2% 79 ± 5</td>
<td>74 ± 5</td>
<td>78 ± 5</td>
</tr>
<tr>
<td>Hb gr/dl 10.4 ± 1.2</td>
<td>7.5 ± 1*</td>
<td>8.9 ± 1*</td>
</tr>
</tbody>
</table>

*p < 0.05 vs control.

Conclusion(s): Student T and Chi squared tests were used for statistical analysis.
the aspirator and by the weight of the gauzes used. The indication of blood transfusion was haemoglobin value of 8.5 g/dl or less. In all patients blood cell counts and serum chemistries were performed every second day until discharge. In addition reticulocytes ferritin and iron were measured at admission, the day of operation and at discharge. For statistical analysis the student t test was used to compare means of measures. The paired t test was used to compare values of hematocrit, haemoglobin, and reticulocytes. In all the patients. Statistical significance was achieved at p < 0.05.

Results and Discussion: Patients who received erythropoietin received significantly fewer transfusion intraoperatively and postoperatively (10 patients with a total of 20 units vs 21 patients with a total of 48 units) p < 0.05. In addition during the postoperative period a markedly increased number of patients (n = 10) from the control group received an allogenic transfusion compared to two patients in the study group who were transfused, p < 0.05. Postoperatively the study group had significantly higher haematocrit, haemoglobin and reticulocytes count values compared to the control group.

Conclusion: Patients who underwent radical prostatectomy benefit from perioperative erythropoietin administration in terms of stimulated erythropoiesis and reduction of blood transfusions.


A-300
New data management solutions improve the logistic and safety of blood transfusion
R. Knels, M. Kurz
Institute Dresden, Red Cross Blood Donation Service Saxony, Dresden, Germany

Background and Goal: The safe production and application of blood products demands high quality logistics. Since the seventies computers and barcodes are used in transfusion medicine for the improvement of the safety of processed data. Now a new technology was developed: radio frequency identification (RFID). The aim of our study was to check, whether RFID can be used reasonably in transfusion medicine.

Material: In the Donation Service in Dresden 1070 passive RFID smart labels were tested under real production conditions. In Vienna 100 RFID smart labels with a multi-sensor system measuring also the temperature of the blood product were tested under simulated “real” conditions, although without patient contact. The data collected were transferred to a new handheld PC software “LabelView”, developed to allow for the monitoring of all steps around the transfusion, including patient identification and the processing of haemovigilance data.

Results and Discussion: Both types of RFID labels survived all steps during the processing of whole blood (e.g. centrifugation) storage, transport and transfusion. The chips even survived under conditions normally not encountered by RPC’s (e.g. freezing in liquid nitrogen). The semiactive label also showed a good correlation (r2 = 0.98) between temperature measured via the chip sensor and via an external infrared sensor. The contactless identification and data storage is of great help in handling documentation of all processing steps according GMP and to provide a means to make transfusion safer.

Conclusion: For a host of problems around blood product use various single point solutions such as patient-wristband, bed-side test, double check of blood group typing and donor-donation registry exist, but for the first time a single system comes into use to combine documentation, safe identification and reporting of haemovigilance data. Additionally, the temperature readings are a means to reduce the disposal rate of RPC’s due to unknown storage conditions. Our investigation shows that the RFID’s and the software used performed flawlessly even under harsh conditions.


Acknowledgements: We thank KSW Microtec AG Dresden for providing the RFID-labels and Novatech Research GmbH Vienna for development “Label View”.

A-301
Transfusion requirements and practices in Austrian hospitals: a prospective benchmark study
Austrian Group for Advanced Blood Management
Department of Anaesthesiology and Intensive Care, General Hospital Linz, Linz, Austria

Background and Goal of Study: Despite detailed transfusion guidelines and continuous educational efforts transfusion practice still varies substantially between hospitals. To assess and optimise the current perioperative use of blood components in public hospitals the Austrian Ministry of Health and women initiated this study.

Materials and Methods: 18 hospitals were selected by stratified randomisation. Strata were three geographical regions and three levels of care. The study group investigated 4 surgical procedures: primary non-cemented hip replacement, primary knee replacement, CABB, and hemicolecotomy. The number of cases to be studied was estimated at 6000 over an 8 month study period. The estimation was based on data of the Ministry of Health and Women collected in 2001. In each of the hospitals an appointed physician – mostly a member of the anesthesia department – entered the data into the central database via web. An independent contract research organisation was responsible for data monitoring. This was done on-line as well as by visiting the study sites. Study variables include preop. Hb, Hb on POD 3 and 5, blood conservation methods, blood components given, complications, length of ICU- and hospital stay.

Results and Discussion: Recruiting started in April 2004 and reached a rate of 550 cases per month after a 2-month run-in phase. More than 60% of the estimated 6000 cases could be included into the study. As of December 2004 more than 85% of the registered cases have been completed and can be evaluated now.

Conclusion(s): Using the above mentioned methods a representative sample of operations could be obtained.

A-302
The impact of acute hypervolemic haemodilution on ELWI, ITBI, CVP, and rcSO2
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Background and Goal of Study: The aim of this study was to evaluate the impact of acute hypervolemic haemodilution on Extravascular Lung Water Index (ELWI), Intrathoracic Blood Index (ITBI), CVP, and regional cerebral oxygen saturation (rcSO2) in burned patient surgery.

Materials and Methods: 30 patients with major burns (>15% BSA) were enrolled in the study. Before the beginning of surgery 6% HES 130/0.4 was infused in a quantity enough to achieve a calculated final haematocrit of 25%. ELWI, ITBI, CVP and rcSO2 were determined at the beginning and at the end of haemodilution. Results were compared using the repeated measures ANOVA.

Results and Discussion: During burned patient surgery major blood loss occurs. Hypervolemic haemodilution has been described as an alternative to reduce hemoglobin loss. However, large volume infusion may cause fluid overload and even pulmonary oedema. In this study, patients were infused 500 to 2500 ml of HES. All patients showed an increase in CVP, ELWI and ITBI. Only ELWI showed a correlation with final haematocrit. HES infusion had to be stopped in 3 cases because of increased ITBI. rcSO2 decreased during haemodilution.

Conclusion(s): ELWI and ITBI are useful indexes of volume load during hypervolemic haemodilution. In contrast to CVP these indexes reflect more accurately the cardiac preload and alert about the risk of pulmonary oedema caused by a fluid overload. In a context of haemodilution and further bleeding as this is, rcSO2 could be used as a transfusion trigger provided the depth of anaesthesia, FiO2, ventilation, and haemodynamics were kept stable.

A-303
The role of antifibrinolytic agents in gynecologic cancer surgery
Department of Anaesthesiology and Reanimation, Hacettepe University Faculty of Medicine, Ankara, Turkey

Background and Goal of Study: The purpose of this study was to compare the effects of the preoperative use of crystalloids, colloids, tranexamic acid and epsilon-aminocaproic acid on bleeding in gynecologic cancer surgery.

Materials and Methods: 105 ASA I-II patients undergoing gynecologic cancer surgery were included in the study. Group I (crystalloid) were given crystalloid solutions, Group II (colloid) were given colloid solutions, Group III (Tranexamic acid) were given 10 mg/kg tranexamic acid, and Group IV (epsilon-aminocaproic acid) were given 100 mg/kg epsilon-aminocaproic acid. All patients’ bleeding amount were measured and recorded perioperatively, and at the 12th and 24th hours postoperatively. All patients’ hemoglobin, hematocrit, aPTT, INR, fibrinogen, and thrombocyte count and symptoms of pulmonary embolism were evaluated preoperatively and at the 12th and 24th hours postoperatively. One-Way analysis of variance, Duncan test and Kruskal-Wallis variance analysis were used to compare the variables in the four groups. Time related variables were analyzed using paired t-test and Wilcoxon test. The differences in variables related to time and coagulation values were analyzed with Chi square and Kappa tests. p < 0.05 were considered as significant.

Results and Discussions: In comparison of the amount of bleeding, the bleeding in the tranexamic acid group was 30.8% less than crystalloid group (p < 0.05), 33.3% less than colloid group (p < 0.05), and 23.9% less than epsilon aminocaproic acid group (p < 0.05). The bleeding in the aminocaproic acid group was 9% and 14% less than the crystalloid and colloid groups but the difference was not significant. In the comparison of tranexamic acid preincisional procedure with acute normovolemic hemodilution and epsilon-aminocaproic acid administration, it clearly decreased the bleeding in gynecologic cancer surgery.

Conclusion: When the negative effects of blood transfusions are considered tranexamic acid administration can be recommended for decreasing the need for blood transfusion in gynecologic cancer surgery.

A-304
The effects of aprotinin on perioperative hyperglycemia in patients undergoing cardiac surgery
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Department of Anesthesiology, Columbia University College of Physicians & Surgeo, New York, USA

Background and Goal of Study: Hyperglycemia during cardiac procedures and cardiopulmonary bypass (CPB) may be severe. The etiology of the disturbance of the plasma glucose-insulin relationship includes inadequate insulin secretion and decreased endogenous insulin activity. It has been postulated that aprotinin may increase the biological effectiveness of insulin by the inhibition of insulin degradation or by decreasing insulin resistance. This putative effect of aprotinin, however, has not been evaluated in cardiac surgical patients.

Materials and Methods: A systematic review of an existing database of cardiac surgery patients at a major U.S. tertiary care medical center was performed. Patients selected met all of the following criteria: the use of CPB, preoperative serum creatinine <1.2 mg/dl, no history of diabetes mellitus, no perioperative insulin or steroid therapy. Patients were then divided into 3 groups; no aprotinin (control), full dose aprotinin (FDA) or half dose aprotinin (HDA). Glucose levels were obtained at predetermined intervals.

Results and Discussions: 96 patients met all of the criteria. Of these, 61 patients were included (TKA 18, control 15). Groups were similar in sex, age, preoperative hematocrit and coagulation parameters. No significant differences were found in fluid administration during perioperative period. No thrombogenic events were observed. Mean (SD) values are summarized below:

<table>
<thead>
<tr>
<th>Glucose (mg/dl)</th>
<th>Drainage blood loss (&lt;5H) (ml)</th>
<th>Drainage blood loss (6-9H) (ml)</th>
<th>Calculated bleeding ml RBC units, Ht 100%</th>
<th>Allogenic transfusion (red blood cells units)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gr. TKA 98(119)</td>
<td>120(134)</td>
<td>387(163)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Gr. control 542(437)</td>
<td>130(119)</td>
<td>527(136)</td>
<td>5</td>
<td>0.173</td>
</tr>
</tbody>
</table>

P < 0.05

Conclusion: Tranexamic acid use before the release of tourniquet and in perfusion during 6 hours after the surgery of knee arthroplasty, reduce the drainage blood loss and the total calculated bleeding at fourth day significantly. Allogenic transfusion index is reduced too, but not significantly in our study.


A-305
Tranexamic acid reduces blood loss in knee arthroplasty
E. Vela, J.C. Alvarez, X. Santiveri, I. Gonzalez, I. Ramos, S. Pacreu, L.I. Aguilera
Department of Anesthesiology, H. del Mar. IMAS, Barcelona, Spain

Background and Goal of Study: Total knee arthroplasty is carried out by using tourniquet, which enhances certain fibrinolytic effect, specially during the first postoperative hours. Tranexamic acid (TKA), antifibrinolytic agent, reduces blood loss in total knee arthroplasty but, its effect in continuous infusion during the immediate postoperative period has never been tested in this kind of surgery.

The objective of our study was to evaluate the effect of TKA on blood loss and its influence in the transfusional needs.

Method: Double blind prospective study. Patients scheduled for total knee arthroplasty were randomly assigned to two different groups. Group TKA: 30 minutes before the tourniquet liberation, a 10 mg/kg bolus of TKA was given, and a 1 mg/kg/h perfusion was started for 6 hours. Group control: SSF was given in the same manner. Blood loss (expressed with drainage volume and total calculated bleeding at fourth day ml of red blood cell units, hematocrit 100%), allogenic or autologous transfusion, and complications were registered. T-test was used for quantitative variables and Chi-square test for qualitative variables.

Results: 33 patients were included (TKA 18, control 15). Groups were similar in sex, age, preoperative hematocrit and coagulation parameters. No significant differences were found in fluid administration during perioperative period. No thrombogenic events were observed. Mean (SD) values are summarized below:

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P < 0.05

Conclusion: Tranexamic acid use before the release of tourniquet and in perfusion during 6 hours after the surgery of knee arthroplasty, reduce the drainage blood loss and the total calculated bleeding at fourth day significantly. Allogenic transfusion index is reduced too, but not significantly in our study.


A-306
Factor VII administration attenuates deleterious consequences of consumptive coagulopathy following amniotic fluid embolism
M. Chaninov, S. Berman, M.L. Cohen, S. Stolero, M. Bahar
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Background and Goal of Study: Amniotic fluid embolism (AFE) is a deleterious, often lethal, pregnancy complication. In as much as 83% of cases, AFE is followed by consumptive coagulopathy, manifested by persistent massive bleeding. During delivery, the management of the latter includes transfusion of large quantities of whole blood and blood components, frequently followed by surgical intervention. We propose a simple method, attenuating the severity of labor-associated, AFE-induced bleeding, and reducing the quantities of blood/blood component transfusions.

Materials and Methods: A 40-year-old female was admitted to the labor ward at the 42nd week of her 12th pregnancy. After 2 h of labor, at full dilatation of the cervix, she suddenly developed typical AFE. She was immediately treated for cardiac complications, and finally the fetus was successfully delivered by forceps extraction. Several minutes after delivery, a severe postpartum hemorrhage and bleeding from the vein puncture sites started,
Additional aspirin effectively shortens bleeding time prolonged by daily low-dose aspirin

Department of Anesthesiology and Critical Care Medicine, Kochi Medical School, Nankoku, Japan

Background and Goal of Study: Discontinuation of anti-platelet drugs several days before surgery increases the risk of ischemic events. Conversely, patients on low-dose aspirin treatment risk of excessive bleeding during emergency surgery. Our preliminary report found that additional 660 mg of aspirin shortened bleeding time prolonged by low-dose aspirin (1). The purpose of the present study was to verify this effect in additional subjects in comparison with a placebo group.

Materials and Methods: Subjects comprised 50 healthy male volunteers (mean age, 24 ± 3 years) who were administered aspirin 81 mg every morning for 7 days. On day 7, Group A (n = 25) received aspirin 660 mg, and Group C (n = 25) received placebo. Bleeding time, maximum platelet aggregation rate induced by adenosine diphosphate (ADP) or collagen, platelet count, prothrombin time (PT), and activated partial thromboplastin time (APTT) were measured before the study (baseline), and before and 2 h after test drug administration.

Results and Conclusion: Bleeding time was significantly prolonged after aspirin 81 mg administration for 7 days, from 3.1 ± 0.7 min to 6.1 ± 1.4 min in Group A (P < 0.01), and from 2.9 ± 0.9 min to 6.1 ± 1.5 min in Group C (P < 0.01). Additional aspirin decreased bleeding time to 4.5 ± 1.3 min (P < 0.01) in Group A, while bleeding time was unchanged in Group C. Platelet count decreased significantly from 252 ± 5.7 × 10^3/mm^3 to 19.5 ± 2.5 × 10^3/mm^3 for a week in Group A, but PT and APTT showed no significant changes. Maximum platelet aggregation rate induced by collagen was significantly decreased, and then induced by ADP also tended to decrease in both groups.

Conclusion: Incremental administration of 660 mg of aspirin could shorten bleeding times prolonged by daily low-dose aspirin.

Reference:

A-308

Additional aspirin shortens bleeding time in patients taking daily low-dose aspirin, but prolongs it in patients treated with ticlopidine

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Department of Anesthesiology and Critical Care Medicine, Kochi Medical School, Nankoku, Japan

Background and Goal of Study: Ticlopidine and low-dose aspirin are often used as anti-platelet drugs. Both drugs are usually discontinued several days before surgery to avoid excessive bleeding during surgery. During emergency surgery, the risk of excessive bleeding has to be considered. Whether additional high doses of aspirin offset the bleeding tendency resulting from low-dose aspirin administration is known as the Aspirin Dilemma (1). The present study investigated the effects of additional aspirin on bleeding time in patients taking ticlopidine or aspirin in comparison with placebo groups.

Materials and Methods: Subjects comprised 41 patients, with 20 patients (13 men; mean age, 67 ± 7 years) on ticlopidine 200 mg/day (Group T), and 21 patients (12 men; mean age, 70 ± 12 years) on low-dose aspirin 81 mg/day (Group A). 12 of group T and 14 of group A took aspirin 660 mg, and others took placebo immediately after measuring bleeding time, capillary fragility test and platelet count. Values were measured again 2h later.

Results and Discussion: Bleeding time was prolonged significantly from 5.1 ± 3.1 min to 9.9 ± 4.2 min after 660 mg of aspirin in Group T (P < 0.01). In Group A bleeding time was shortened significantly from 7.3 ± 3.1 min to 3.4 ± 1.6 min (P < 0.01). However, there was no significant difference in patients administered placebo in both groups. No significant differences in capillary fragility test or platelet count were noted between groups, either before or after administration of additional aspirin or placebo.

Conclusion(s): Administration of an additional 660 mg of aspirin prolongs bleeding time in patients taking daily ticlopidine, but shortens bleeding time in patients taking daily low-dose aspirin. Additional aspirin may be useful in patients taking low-dose aspirin to help prevent hemorrhaging during emergency operation. Conversely, aspirin should be used carefully for analgesia in patients taking ticlopidine.

Reference:
1. Marcus AJ. MEJM. 1877; 297: 1284–1285.
A-313
Respiratory complications in patients after surgery for aneurismal subarachnoid bleeding
A. Hoxha, K. Pilika, O. Gjini, L. Agolli, M. Demneri, N. Filipi, M. Saraçi
Department of Anesthesia and Intensive Care, University Hospital Center “Mother Theresa”, Tirana, Albania

Background and Goal of Study: The goal of our study is to evaluate the relationship between neurological impairment and the intensity of the respiratory complications in our patients. (1)

Materials and Methods: Study is performed in a group of 151 patients suffering from aneurismal subarachnoid bleeding. Pulmonary function was evaluated through measurement of parameters reflecting its impairment using a quantitative system of measurement (lungen injury score-LIS) reflecting the intensity of the acute lung injury. Evaluation of mechanical support provided to patients under mechanical ventilation is performed using PIF index (2). To assess the neurological impairment the Hunt and Hess scale was used. The incidence of multi organ failure (MOF) and mortality rate are considered in relationship to neurological impairment and to acute lung injury developed.

Results and Discussion: In our patients is shown a strong correlation (r = 0.88) between the level of neurological impairment and the lung injury score (LIS) prior and after the clipping of the aneurism. Vasospasm and its neurological impact are major determinants of the incidence of the impairment of the respiratory function. Mortality rate in the group was 13.91% (21 from 151). Disorders not related to neurological impairment are responsible for 38.01% (8 from 21) of mortality. In most of the cases multi organ failure (MOF) was the cause death. Acute lung injury differs significantly among patients depending on their Hunt and Hess grade (p < 0.05). Hunt and Hess grade as well as the severity of the acute lung injury are strong predictor (r = 0.79) of patient outcome, too.

Conclusions: Severity of the acute lung injury is in close relationship to Hunt and Hess grade of the patient and both are a major predictor of the patient outcome.

References:

A-314
Intraoperative visualization of deep seated expanding brain lesions with contrast ultrasound
F. Bilotta, V. Fabbrini, R. Caramia, C. Maurizio, G. Centola, G. Branca, F. Aramo, A. Santoro, R. Delfini, G. Rosa
Department of Anesthesiology, Intensive Care and Pain Medicine, Neuroanesthesia, Rome, Italy

Background and Goal of Study: During neurosurgery for deep-seated brain lesions intraoperative identification sometimes entails transporting the patient to the imaging suite. An alternative technique for intraoperative visualization is direct brain ultrasound scanning. Owing to the limited difference in ultrasound lesion scattering, contrast-enhancement might improve visualization. In this study, we investigated whether SHU 508A injected intravenously during mechanical ventilation opacifies the right and left ventricular cavities after lung transit, reaches the cerebral circulation and visualizes deep-seated expanding brain lesions.

Materials and Methods: Twenty-five patients undergoing neurosurgical procedures for supratentorial expanding lesions were prospectively enrolled. All patients received intravenous SHU 508A, during spontaneous breathing (baseline), 5 min after mechanical ventilation began, and 5 min and 30 min after extubation. Of the 25 patients, 10 undergoing intraoperative open-skull brain ultrasound scanning to visualize deep-seated lesions received an additional dose of SHU 508A to investigate cerebrovascular contrast distribution within the lesion. After intravenous contrast injection, we evaluated pulmonary transit time and cardiac chamber opacification; the time for contrast to reach the cerebral circulation; the time it remained in the brain; and its distribution within the expanding brain lesions.

Results and Discussion: In all patients, SHU 508A passed through the lungs with a constant physiologic transit time; opacified both cardiac chambers; reached the cerebral circulation in a physiologic time and visualized the deep-seated expanding brain lesions.

Conclusions: Intravenous SHU 508A provides physiologic pulmonary capillary transit during mechanical ventilation, reaches the cerebral circulation and visualizes deep-seated expanding brain lesions in patients undergoing intraoperative cerebral ultrasound scanning.

A-315
Postoperative hypertension after craniotomy and catecholamine secretion
A. Hoxha, M. Demneri, K. Pilika, O. Gjini, N. Filipi, M. Saraçi, N. Marku, A. Bulo, E. Refatllari
Department of Anesthesia and Intensive Care, University Hospital Center “Mother Theresa”, Tirana, Albania

Background and Objective: Hypertension after craniotomy is frequent. It has been assumed that the stress of recovery is at least as great as that of surgery. Hypertension after craniotomy is higher compared to other types of surgery. The goal of the study is to figure out the association between catecholamine dynamic in blood and postoperative hypertension with or without high heart rates.

Methods and Materials: Twelve patients (age 40.33 ± 22.23), without preoperative history of hypertension, after planned craniotomy and normal per-operative history, were selected. Mean arterial blood pressure (MAP), heart rate and plasma concentrations of Epinephrine (E) and Nor-epinephrine (NE) were measured at three moments: 20 minutes after halothane discontinuation, one and two hours after that (moments 1;2;3). Data are given as mean ± SD (range), p ≤ 0.05 is considered as statistically significant.

Results: Seven of the patients had normal blood pressure postoperatively (group N) and five others developed postoperative hypertension (group H) defined as MAP > 20% more than the baseline. The mean value of MAP measured in groups H and N, was 114.8 ± 15.5 mmHg (range: 98–134) and 103 ± 11.9 mmHg (range 73–100) (p ≤ .01). Postoperative catecholamine plasma concentrations were much higher in group H. The mean value of Epinephrine (E) was 464.0 ± 295.4 pg/ml and of Norepinephrine (NE) was 886.7 ± 495.3 pg/ml, compared with those of group N (Epinephrine (E) = 191.8 ± 104.7 pg/ml and Norepinephrine (NE) = 574.7 ± 529.3 pg/ml). Difference in catecholamine plasma levels persists in all check moments.

Conclusion: These results suggest that an increased discharge of sympathetic system may play an important role in the development of postoperative hypertension after craniotomy. This observation may indicate a rational approach for treatment of postoperative hypertension after craniotomy.

Reference:
A-316
Postoperative hypertension (HTN) following craniotomies for tumour: incidence and predictive factors
L. Venkat Raghavan, A. Prabhu, K. Lukitto
Department of Anesthesia, Toronto Western Hospital, Toronto, Canada

Background and Goals of Study: Systemic hypertension (HTN) is a risk factor for postcraniotomy intracranial hematoma\(^1\). Studies have quoted 20 to 80% incidence of HTN following craniotomies for tumour\(^2\). However, these studies have not had incidence of HTN as the primary endpoint. The purpose of this study is to determine the true incidence of postoperative HTN, and identify predictive factors.

Material and Methods: After IRB approval, all consented patients undergoing craniotomy for tumor were prospectively followed. Data collected included patient demographics, surgical data, hemodynamic parameters, complications and outcome. Hypertension was defined as a value of greater than 160/90 mmHg lasting longer than 5 minutes. Statistical analyses were by Chi-Square test and t-tests.

Results: 108 patients were followed. 37(34.2%) patients were hypertensive in the postoperative period. 10 patients with treatable causes of HTN (pain, hyperventilation, vomiting) were excluded. True incidence of hypertension was 25%. There were no demographic differences between the groups. Results are shown in the table.

Results and Discussions: A pilot study

A-317
Effects of fentanyl and S(+)ketamine on gastrointestinal motility and catecholamine dosages in neurosurgical patients – a pilot study
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Background and Goals: In neurosurgical patients, narcotics are usually administered to prevent secondary cerebral damage due to elevated intracranial pressure (ICP) and to provide conditions favouring the recovery of brain tissue. Intestinal atonia and a decrease in blood pressure affording the use of vasopressors, however represent complications often related to the type of anesthesia being used. The aim of the present study was to evaluate gastrointestinal motility and catecholamine consumption in neurosurgical patients undergoing two different protocols of anesthesia using fentanyl/methohexitol, and S(+)ketamine/methohexitol.

Material and Methods: Twenty-four patients (mean age 52 ± 17 years) were included in the study. Eight patients undergoing severe traumatic brain injury or aneurysmal subarachnoid haemorrhage received either fentanyl/methohexitol or S(+)ketamine/methohexitol in a prospectively controlled randomised trial. In both groups, patients with weight near 120 kg were also successfully cooled; expanded volume of saline was 35–40 ml/kg. Time interval from beginning of the cooling to achieving target temperature was 1.5–2.5 hours. Most frequent adverse effects: bradycardia (responsive to atropine and to decreasing rate of bolus infusion); cold diuresis, that can contribute to hypovolemia; trend to low normal serum potassium (3–3.5 mmol/l) and hypoglycemia (7–11 mmol/l); retarded recovery; prolonged intubation and ventilation; shivering at emergence. None from these effects caused break of the cooling.

Conclusion: In our study true incidence of post craniotomy HTN is 25%. Chronic HTN and raised intracranial pressure are significant predictive factors. These results are preliminary and more numbers are needed to identify risk factors.

References:

A-318
Developing of reliable and safe technique for induction of mild hypothermia during cerebral aneurysm surgery
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Background and Goal of Study: Efficacy of hypothermia is heavily depend-ent on proper technique and timing. We performed current study for assessment of efficacy and safety of intraoperative induction and maintenance of mild hypothermia to core temperature of 33–37°C. The technique involved forced air, circulating water mattress, and i.v. bolus infusion of iced slushed saline.

Materials and Methods: We included in study 50 consecutive patients undergoing open cerebral aneurysm surgery. Range of the weight was 50 to 120 kg. Core temperature monitoring used nasopharyngeal probe. Core temperature immediately after induction was 35.8–37°C. After induction of anaesthesia we began forced air cooling (set for ambient air) and cooling by circulating water mattress (set for 4°C), infused 2.5 g MgSO\(_4\) and after stabilization infused iced slushed saline (4°C) through two lines (central 14–16G and periferal 18G) until approaching target temperature. We adjusted ventilation to keep PaCO\(_2\) 32–35 mm in pH-stat mode.

Results and Discussions: All patients with weight <90 kg were successfully cooled to 32–33°C; expanded volume of saline was 15–30 ml/kg. Low-weight patients (<55 kg) in whom we require iccd saliend for cooling. For patients with weight near 120 kg were also successfully cooled; expanded volume of saline was 35–40 ml/kg. Time interval from beginning of the cooling to achieving target temperature was 1.5–2.5 hours. Most frequent adverse effects: bradycardia (responsive to atropine and to decreasing rate of bolus infusion); cold diuresis, that can contribute to hypovolemia; trend to low normal serum potassium (3–3.5 mmol/l) and hypoglycemia (7–11 mmol/l); retarded recovery; prolonged intubation and ventilation; shivering at emergence. None from these effects caused break of the cooling.

Conclusion: (1) Combination of forced air, circulating water mattress and i.v. bolus infusion of slushed iced saline is effective and safe technique for induction of mild hypothermia (32–33°C) during cerebral aneurysm surgery. This technique is effective in significantly overweight patients just as well. (2) Timing of this technique is fast enough for achieving of target temperature until the beginning of surgical dissection of intracranial vessels. (3) Profile of associated adverse effects is acceptable in face of brain ischemia.

A-319
Use of bispectral Index (BIS) to guide the anesthetic management for wake-up craniotomy
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Introduction: Wake-up craniotomy has been advocated as the solution for patients undergoing epilepsy surgery or tumor surgery in eloquent areas of the brain. The anesthetic challenge is to provide as well adequate analgesia, sedation, hemodynamic stability, as a safe airway, with an awake cooperative patient for neurological testing. In the present paper, we want to illustrate how we used BIS, which is a measure of the hypnotic component of anesthesia, to guide our anesthetic management during wake-up craniotomy.

Materials and Methods: In this paper, we report on 6 adult pts scheduled for brain tumor surgery in eloquent areas of the brain. Following premedication (midazolam 7.5 mg po), induction was accomplished with propofol TCI (B [3 μg/ml), remifentanil TCI (8 ng/ml) and rocuronium (0.6 mg/kg). After insertion of a laryngeal mask airway (LMA), anesthesia was maintained with propofol TCI (titrated to BIS between 40 and 60) and remifentanil TCI (titrated to hemodynamic responses). Surgical field was infiltrated with up to 30 ml bupivacaine 0.5%. For neurological testing (and wake-up) TCI propofol/remifentanil was gradually (minus 10% of initial rate) reduced according to a BIS value between 60 and 80. When BIS was higher than 80, pt was...
stimulated, LMA was removed and propofol–remifentanil TCI was main-
tained according to a BIS value between 80 and 90.

Results: In all 6 pts, the wake-up procedure was successfully managed. In a mean of 18 min (range 14–31 min) after start of the wake-up procedure, BIS values higher than 60 were obtained. At this time, mean propofol TCI was 2.1 μg/ml and mean remifentanil TCI was 3.5 ng/ml. Infusion rates were further decreased in order to reach BIS values higher than 80 (mean propofol 1.3 μg/ml and mean remifentanil 2.1 ng/ml). All pts were arousable, LMA was removed, and neurological testing was started (for a mean of 37 min). Hemodynamic parameters remained stable, respiratory rate and arterial PCO₂ remained within normal limits. No pt experienced any anxiety or pain. In 4 pts, the end of the surgical procedure was performed under local anesthesia. Anesthetic management for awake craniotomy can be strictly guided BIS monitoring, allowing smooth and safe transition from anesthesia to conscious sedation with great patient satisfaction.

A-320
Factors that may predict and influence postoperative neurological recovery in posterior fossa surgery
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Background and Goal of Study: Posterior fossa (PF) surgery is a small, con-
stricted space. Any space occupying lesion can block CSF flow and cause
pressure on vital brain structures resulting in increased morbidity and mor-
tality. The goal of the study was to determine the factors affecting short term neurological outcome in patients undergoing PF surgery upon ICU discharge.

Materials and Methods: We retrospectively analyzed the clinical, radiolog-
ic and operative findings of 194 patients that underwent PF surgery at our institution over the last 10 years. The patients were divided in two groups. Group A: ICU stay <2 days (n = 142), group B: ICU stay >2 days (n = 52). The following parameters were recorded: age, ASA-PS, preoperative GCS, CT-scan grade, anasthesia and surgery duration, presence of CSF drainage, APACHE II (acute and chronic health state) score upon ICU admission and GOS. Statistical analysis was performed using Mann Whitney, chi-square and multivariate stepwise regression.

Results and Discussion: Overall mortality was 3.05%. No statistically sig-
nificant difference was noticed regarding age or ASA-PS. Parameters signif-
ically associated with ICU stay are referred to in the table. CT scan grade, duration of surgery, APACHE II score and CSF drainage were factors that predicted 82% of the variance of prolonged ICU stay.

<table>
<thead>
<tr>
<th></th>
<th>A (n = 142)</th>
<th>B (n = 52)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>GCS*</td>
<td>14.8 ± 0.7</td>
<td>13.9 ± 2.9</td>
<td>0.000</td>
</tr>
<tr>
<td>CT-scan grade 5</td>
<td>4 (15.8%)</td>
<td>22 (84.8%)</td>
<td>0.000</td>
</tr>
<tr>
<td>APACHE II</td>
<td>7.3 ± 3.5</td>
<td>9.6 ± 5.1</td>
<td>0.004</td>
</tr>
<tr>
<td>Surgery (h)*</td>
<td>4.5 ± 1.6</td>
<td>5.6 ± 2.3</td>
<td>0.005</td>
</tr>
<tr>
<td>Anesthesia (h)*</td>
<td>5.7 ± 1.7</td>
<td>8.9 ± 2.4</td>
<td>0.004</td>
</tr>
<tr>
<td>CSF-drainage</td>
<td>20 (14.1%)</td>
<td>25 (49%)</td>
<td>0.012</td>
</tr>
<tr>
<td>GOS 1-3</td>
<td>3 (2.1%)</td>
<td>14 (28.9%)</td>
<td>0.000</td>
</tr>
</tbody>
</table>

*mean ± SD

Conclusion: CT-scan grade, duration of surgery, APACHE II score as well as the presence of CSF drainage affected short term neurological outcome (GOS) and ICU stay in an important manner.

A-321
Mitochondrial ATP-sensitive potassium channel blocker
dose not attenuate ischemic and hypoxic preconditioning
on hypoxic-ischemic brain injury in the neonatal rat
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Background and Goal of Study: Involvement of mitochondrial adenine
triphosphate-sensitive potassium (K_ATP) channels in the development of
ischemic tolerance has been suggested in the rat. In this study, we examined
the effect of selective mitochondrial K_ATP channel blocker 5-hydroxydecanoate
(BHD) on ischemic and hypoxic preconditioning in the neonatal rat brain.

Materials and Methods: Seven-day old Sprague-Dawley rat pups were divided into five groups: control (C, n = 91), ischemic preconditioning (IP, n = 51), hypoxic preconditioning (HP, n = 39), pretreatment ischemic pre-
conditioning (PPIP, n = 52), and pretreatment hypoxic preconditioning (PHIP,
n = 43). Thirty minutes before preconditioning, PIP and PHIP received
60 mg/kg intraperitoneal SHD. For IP and PIP, the right common carotid
terminal artery was occluded for 10 min. Rats in HP and PHIP were kept under
hypoxic (8% oxygen, 92% nitrogen) conditions for 4 h. Twenty-four hours
after the preconditioning, rats from all groups were exposed to the right
carotid artery ligation, followed by 2.5 h of hypoxia. Triphenyl tetra-
zo-tetrazolium chloride (TTCl staining and terminal deoxynucleotidyld
transferased mediated dUTP-biotin nick end-labeling (TUNEL) were evaluated
as measures of infarct and apoptosis 1 and 7 days after hypoxic-ischemic
injury. In addition, all rats were sacrificed 2 weeks after hypoxic-ischemic
brain injury, and the morphologies of the brains were examined.

Results: In the pretreatment and preconditioning groups, the infarct size of
TTC staining, the numbers of TUNEL-positive cells, and the degree of mor-
phologic changes were significantly lower than those in the control group
(p < 0.05), but there were no significant differences between the four pre-
treatment and preconditioning groups.

Conclusion: These results suggest that mitochondrial K_ATP channel blocker
SHD dose not attenuate ischemic and hypoxic preconditioning on hypoxic-
ischemic brain injury in the neonatal rat.

A-323
Interleukin-18: a new marker of neurocognitive dysfunction
after cardiac surgery
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Background and Goal of Study: Neurological injury following cardiopul-
monary bypass (CPB) remains a potentially devastating consequence of heart
surgery. Increased expression of Interleukin-18 (IL-18), a proinflammatory
cytokine, is seen in the acute ischaemic stroke patient [1]. This study inves-
tigates our hypothesis that IL-18 may be used as a marker of neurological
dysfunction after cardiac surgery.

Materials and Methods: With ethical approval and informed patient con-
tent, 30 patients (24 male, 6 female, age 62 ± 10) undergoing elective car-
diac surgery (CABG 27, Valve Replacement 2, ASD repair 1) using CPB were
enrolled. IL-18 blood samples were taken: before induction, 10 min post
CPB, 6, 24, 48, 72, 96 h post CPB, at discharge and 6 weeks. Patients were
assessed using a battery of 9 neuropsychometric tests [2] preoperatively, at
5 days and 6 weeks postoperatively. A patient was considered to have a
major deterioration in a test if the score deteriorated by 1 SD of the baseline
score for all patients. Neurocognitive impairment was defined as a major
deterioration in two or more tests and was examined at 2 time intervals from:
pre-operatively (baseline) to day 5 and baseline to 6 weeks. The peak differ-
ence of IL-18 was calculated from the peak and baseline values. Logistic
regression was used to investigate the effect of peak difference of IL-18 on
neurological outcome.

Results and Discussion: 8 patients had neurocognitive impairment
between 5 days and baseline. Neurological outcome was significantly
dependent on the peak difference in IL-18; p = 0.033.

<table>
<thead>
<tr>
<th>Time intervals</th>
<th>Baseline to day 5</th>
<th>Baseline to 6 week</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of patients</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>p values</td>
<td>0.033</td>
<td>0.29</td>
</tr>
</tbody>
</table>

Conclusion: IL-18 may be a useful marker of neurological dysfunction
after cardiac surgery. Further investigation is required.

References:

A-325
Influence of sevoflurane on the neuroregenerative potency
of the brain after cerebral ischemia
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Mainz, Germany

Introduction: The present study investigates the effect of halothane and
sevoflurane on the neuroregenerative potential of the brain after cerebral
ischemia

Methods: Following approval of the institutional animal care committee 48
male Sprague-Dawley rats were intubated, anesthetized and ventilated with
halothane. After insertion of catheters and preparation of the carotid arteries animals were randomized to six different treatment groups (n = 8 per group). Animals of all groups received 25 μg/kg/h fentanyl i.v. and were ventilated with O₂ and air (FiO₂ = 0.33). In groups 1 and 2 animals additionally received 0.8 MAC halothane, in groups 3 and 4 animals received 0.8 MAC sevoflurane and in groups 5 and 6 animals received 1.6 MAC sevoflurane. In the sham operated groups 1, 3, and 5 no cerebral ischemia was performed. In ischemic groups 2, 4, and 6 ten minutes of forebrain ischemia was induced by bilateral carotid artery occlusion plus hemorrhagic hypotension to a mean arterial blood pressure of 40 mmHg. Pericranial temperature, arterial blood gases and pH were maintained constant. Upon recovery from anesthesia and return to their home cages bromodeoxyuridine (BrDU, 100 mg/kg) was administered i.p. for seven postischemic days as a marker of newly generated cells. At the end of a 28 days observation period animals were killed in deep anesthesia, perfused with paraformaldehyde, and brains were removed and stored at −20°C. Histological damage of the hippocampus was evaluated in 40 μm slices stained with hematoxylin and eosin. Immunohistochemistry was used to detect cells in the dentate gyrus with a positive staining for BrdU. Eight non-ischemic animals were used as a naive control. Statistics: Two way ANOVA (p < 0.05; mean ± standard deviation).

Results: In animals subjected to cerebral ischemia 10% of the hippocampal CA1 region was damaged, regardless of the choice or concentration of the anesthetic agent. After cerebral ischemia an increase of newly generated cells in the dentate gyrus by 100% was observed with halothane and 1.8 MAC sevoflurane. Four hours of anesthesia with halothane or sevoflurane in the absence of cerebral ischemia did not influence neurogenesis.

Discussion: Histopathologic damage was observed after cerebral ischemia with both anesthetic agents. At the same time halothane and sevoflurane allowed an ischemia-induced increase of neurogenesis in the dentate gyrus. These data show, that halothane and sevoflurane are suitable as background anesthetics for stem cell research, as both agents lack intrinsic effects on stem cell activity, while they allow for a ischemia induced proliferation of stem cells.

A-326 Correlation between continuously monitored regional cerebral blood flow and brain tissue oxygenation
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Background and Goal of Study: Cerebral tissue oxygenation (pO₂) is thought to be predominantly influenced by cerebral blood flow (CBF). Just recently, a thermodiffusion-probe has been developed for continuous monitoring of regional CBF in patients. The goal of this study was to investigate the relationship between regional pO₂ and CBF.

Materials and Methods: In eight patients with either subarachnoid hemorrhage (n = 5) or severe traumatic brain injury (n = 3), both regional pO₂ and CBF were simultaneously monitored for an average of 9.6 days. pO₂ and CBF were assessed using a flexible polarographic Clark-type microcatheter (Licox, Integra Neurosciences) and a thermodiffusion probe (QFlow 400, CBFI). Results and Discussions: Four hundred 30-min. intervals were analysed, of which a close correlation (r=0.9927, p<0.001) between regional pO₂ and CBF were assessed using a flexible polarographic Clark-type microcatheter (Licox, Integra Neurosciences) and a thermodiffusion probe (QFlow 400, CBFI). In the sham operated groups 1, 3, and 5 no cerebral ischemia was performed. In ischemic groups 2, 4, and 6 ten minutes of forebrain ischemia was induced by bilateral carotid artery occlusion plus hemorrhagic hypotension to a mean arterial blood pressure of 40 mmHg. Pericranial temperature, arterial blood gases and pH were maintained constant. Upon recovery from anesthesia and return to their home cages bromodeoxyuridine (BrDU, 100 mg/kg) was administered i.p. for seven postischemic days as a marker of newly generated cells. At the end of a 28 days observation period animals were killed in deep anesthesia, perfused with paraformaldehyde, and brains were removed and stored at −20°C. Histological damage of the hippocampus was evaluated in 40 μm slices stained with hematoxylin and eosin. Immunohistochemistry was used to detect cells in the dentate gyrus with a positive staining for BrdU. Eight non-ischemic animals were used as a naive control. Statistics: Two way ANOVA (p < 0.05; mean ± standard deviation).

Results: In animals subjected to cerebral ischemia 10% of the hippocampal CA1 region was damaged, regardless of the choice or concentration of the anesthetic agent. After cerebral ischemia an increase of newly generated cells in the dentate gyrus by 100% was observed with halothane and 1.8 MAC sevoflurane. Four hours of anesthesia with halothane or sevoflurane in the absence of cerebral ischemia did not influence neurogenesis.

Discussion: Histopathologic damage was observed after cerebral ischemia with both anesthetic agents. At the same time halothane and sevoflurane allowed an ischemia-induced increase of neurogenesis in the dentate gyrus. These data show, that halothane and sevoflurane are suitable as background anesthetics for stem cell research, as both agents lack intrinsic effects on stem cell activity, while they allow for a ischemia induced proliferation of stem cells.

A-327 Oxidative stress response of remifentanil-based anaesthesia with isoflurane or propofol in craniotomy operations
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Background and Goal of Study: Excess of free radicals, known as oxidative stress, is the major cause of neurologic injury (1). In this presenting study, our aim was to examine effects of two anaesthesia techniques on oxidative stress response via malondialdehyde (MDA), a lipid peroxidation by-product, in craniotomy procedures.

Materials and Methods: Forty patients scheduled for craniotomy were enrolled into two groups to receive either isoflurane-remifentanil (Group I) or propofol-remifentanil (Group II) anaesthesia. MDA samples were obtained at four time points: before intubation (PRE), after intubation (INT) and during incision (DUR) and at 60th minutes (60M), after extubation (EXT) and at postoperative 1st (P1) and 24th (P24) hour. Haemodynamic measurements were performed simultaneously and also after skull pin placement and craniotomy and at every 30 minutes during the procedure.

Results and Discussions: All patients were comparable with respect to demographic properties. Both isoflurane and propofol in conjunction with remifentanil anaesthesia provided considerable haemodynamic stability. Oxidative stress response pattern via MDA was similar in both groups intraoperatively, whereas postoperative 1st hour value was significantly higher in propofol group. Data (Mean ± SD) are shown in the table:

<table>
<thead>
<tr>
<th>MDA (nmol/ml)</th>
<th>GROUP I</th>
<th>GROUP II</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRE</td>
<td>10.66 ± 4.03</td>
<td>12.72 ± 3.39</td>
</tr>
<tr>
<td>INT</td>
<td>15.73 ± 4.87*</td>
<td>16.99 ± 4.68*</td>
</tr>
<tr>
<td>DUR</td>
<td>12.82 ± 4.19</td>
<td>13.77 ± 4.63</td>
</tr>
<tr>
<td>60M</td>
<td>13.02 ± 5.59</td>
<td>13.87 ± 3.44</td>
</tr>
<tr>
<td>EXT</td>
<td>13.69 ± 5.12</td>
<td>12.06 ± 3.92</td>
</tr>
<tr>
<td>P1</td>
<td>11.89 ± 5.86</td>
<td>16.28 ± 4.29*</td>
</tr>
<tr>
<td>P24</td>
<td>12.58 ± 4.61</td>
<td>13.80 ± 3.17</td>
</tr>
</tbody>
</table>

*p < 0.05: comparison with preoperative value within group.
+p < 0.05: between groups.

Conclusion: Neither of the techniques could be respected as superior in preventing the oxidative stress response.

References:

A-328 Factors affecting brain tissue oxygen tension: a computational modelling study
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Background and Goal of Study: Computational modeling allows theoretical investigation of factors promoting cerebral tissue hypoxia. Previous models have focused on describing oxygen flux at just the capillary-tissue interface. (1) Using a previously described model (2) of cerebral haemodynamics and gas exchange we studied the effect of arterial hypoxia, arterial hypotension and brain tissue swelling in otherwise normal brains.

Materials and Methods: The model consists of serial vascular beds confined within a non-compliant cranium. Arterial resistance is responsible to changes in cerebrospinal fluid pH, arterial transmural pressure and cerebral blood flow. The partial pressure of oxygen in brain tissue (PinO₂) is a complex function of arterial oxygen saturation/partial pressure (SaO₂/PaO₂), tissue volume, distance from capillary, capillary pH, PaCO₂ and oxygen solubility and diffusivity in brain tissue. The simulation was set up with normal parameters for autoregulation and intracranial CSF dynamics, PinO₂ was calculated over a range of mean arterial pressure, SaO₂ and tissue volume.

Results and Discussions: Between 70 and 150 mmHg mean arterial pressure (MAP), PinO₂ increased from 3.1 to 3.9 kPa. Below 70 mmHg MAP, PinO₂ fell by 0.05 kPa mmHg⁻¹. The fall in PinO₂ as SaO₂ was reduced was greater between 90 and 100% SaO₂ (0.075 kPa% SaO₂⁻¹) than 85 and 90% (0.059 kPa% SaO₂⁻¹). Increasing tissue volume by 10% lowered PinO₂ across the range of MAP and SaO₂. The lowest PinO₂ was 0.71 kPa (MAP 60 mmHg, SaO₂ 85%, 10% oedema). The model predicts that in normal brains, moderate hypotension and hypoxia even when combined are not enough to generate critical cerebral ischaemia. Modest degrees of oedema may allow critical ischaemia to occur. The results are consistent with published clinical data (1).

Conclusions: This computational model can provide useful data regarding the pathological factors which, when combined, predispose to critical cerebral ischaemia.

References:
A-329
Effects of the intracerebroventricular application of insulin-like growth factor (IGF) and its N-terminal tripeptid (GPE) on cerebral recovery after cardiac arrest in rats
E. Popp, P. Vogel, P. Teschenhöfer, W.R. Schaeblitz, S. Schwab, B.W. Boettiger
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Background and Goal of Study: After transient global cerebral ischaemia, selectively vulnerable brain areas show delayed neuronal degeneration (1). Recent data demonstrated potent neuroprotective effects of the application of growth hormones like IGF (insulin-like growth factor) and its cleavage product GPE (glycine-proline-glutamate) after focal cerebral ischaemia (1, 2). In order to assess possible effects of the intracerebroventricular application of IGF and GPE on cerebral recovery after cardiac arrest in rats, the vulnerable hippocampal CA1 sector was investigated.

Materials and Methods: After approval was obtained from the Governmental Animal Care Committee, global cerebral ischaemia was initiated by ventricular fibrillation in rats during general anaesthesia. After 6 min, animals were resuscitated by external cardiac massage combined with defibrillation and divided into three groups (IGF vs. GPE vs. placebo). Continuous application of IGF (1.25 μg/h), GPE (5 μg/h) and placebo was performed during the complete reperfusion time using an implanted osmotic pump (n = 6 per group) corona lobar sector were analyzed by TUNEL- and Nissi-staining. Viable and TUNEL positive neurons were counted in the hippocampal CA1 sector. All experiments were performed in a randomized and blinded setting. For statistical analysis the Kruskal-Wallis, the Wilcoxon and the Chi-square test (mean ± SEM; p < 0.05 = significant) were used.

Results and Discussions: In all groups typical delayed neurodegeneration could be found in the hippocampal CA1 sector. Interestingly, animals treated with IGF and GPE showed a strong trend towards more viable neurons than placebo treated rats (IGF: 54 ± 21; GPE: 53 ± 24; placebo: 40 ± 21; p = ns). Results from TUNEL staining revealed no differences between the groups (IGF: 21 ± 7; GPE: 17 ± 7; placebo: 20 ± 6).

Conclusion(s): Despite the well known neuroprotective properties of IGF and GPE in ischemic neuronal degeneration, this model could not reveal significant beneficial effects after cardiac arrest in rats. However, a trend towards neuroprotective effects of IGF and GPE could be seen and should be investigated in detail.

References:

A-330
The attenuation of vasospasm by using dexmedetomidine after experimental subarachnoid haemorrhage model in rabbits
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Background and Goal of Study: Vasospasm that leads to brain ischaemia following subarachnoid haemorrhage (SAH) can be defined as narrowing of brain arteries focally or diffusely. Dexmedetomidine is used for sedation in intensive care units nowadays. The mechanism of neuroprotection by dexmedetomidine is still unclear. Acute vasospasm following SAH occurs by 48 hours. In our study, we wanted to study if vasospasm following subarachnoid haemorrhage can be alleviated by using dexmedetomidine.

Materials and Methods: The experimental subarachnoid haemorrhage, in concentrations of 0.9 ml of autologous arterial blood/1 kg of body weight was carried out in 18 New Zealand rabbits. Rabbits were infused either 0.9% sodium chloride or 5 μg/kg/h dexmedetomidine for two hours, 48 hours after subarachnoid haemorrhage was established. Third group was the sham control group. Histological specimens were obtained by fixation of brains of rabbits after they were sacrificed. The occlusion effect of experimentally induced subarachnoid hemorrhage was determined by computer image analysis of rabbit basilar arteries that were photographed under microscopy. Statistical analysis was by a one-way ANOVA with Tukey's test. Values are expressed as mean ± SD, and n = 6 for all groups.

Results and Discussions: Thickness of basilar artery was significantly thick in SAH group than the others (p < 0.05). Morphometric diameter was significantly narrower in SAH group than the others. SAH-Dexmedetomidine group revealed attenuation of vasospasm, formed after 48 hours.

Conclusion(s): Our study showes that vasospasm is attenuated by dexmedetomidine when it is used after acute vasospasm is formed as our study is compared with a previous study (1) that showed clonidine, another α2 agonist, prevented chronic vasospasm.

Reference:

A-331
The effects of endotracheal tube lidocaine administration on endotracheal suctioning-induced increases in intracranial pressure in head-injured patients
F. Biotta, C. Maurino, R. Caramia, G. Branca, G. Centola, F. Ferri, F. Giovannini, M. Pennacchia, P. Pietropaoli, G. Rosa
Department of Anaesthesiology, Intensive Care and Pain Medicine, Neuroanesthesiology, Rome, Italy

Background and Goal of Study: In patients with severe traumatic brain injury, endotracheal suctioning can result in a number of undesirable side effects including hypertension, tachycardia and increased intracranial pressure. To avoid these effects we evaluated the use of endotracheal tube lidocaine administration. Lidocaine inhibits neuronal transmission by its action in stabilizing the neuronal membrane (central nervous effects) thus is suitable for the acute phase of traumatic brain injury.

Materials and Methods: Twenty-five patients mechanically ventilated after neurological procedures for head trauma were prospectively enrolled. Patients that coughed and/or moved during endotracheal suctioning were enrolled and received 2 ascending doses of endotracheal lidocaine: low-dose 1 (1 mg/kg bolus) and high-dose 2 (2 mg/kg bolus). The presence of coughing during endotracheal suctioning after endotracheal lidocaine administration was recorded as failure. The endotracheal suction protocol was performed 20-min after bolus administration with increase of FiO2 to 100% for 60 s and insertion of standardized suction catheter by the side port of the endotracheal tube for <30 s. Heart rate, ICP mean arterial blood pressure and cerebral perfusion pressure were continuously monitored. ICP was continuously monitored with Rehau System (Switzerland). Ventilation tidal volume or respiratory rate) was adjusted to maintain PCO2 between 33 and 37 mmHg.

Results and Discussions: In 17 patients out of 25 (68%) low-dose lidocaine effectively prevented coughing during endotracheal suctioning, while the high-dose lidocaine was effective in 21 out of 25 (84%) in preventing cough during endotracheal suctioning. Mean arterial pressure decreased significantly after endotracheal tube lidocaine administration but ICP and cerebral perfusion pressure did not decreased significantly.

Conclusions: The present study shows that endotracheal tube lidocaine administration used in patients with severe traumatic brain injury reduces the cough reflex during endotracheal suctioning in a dose-dependent manner. Endotracheal lidocaine administration did not alter brain blood autoregulation and allows adequate cerebral perfusion.
Our data confirm that patients with impaired pressure autoregulation are at high risk to develop secondary cerebral hypoxia and to achieve an unfavorable outcome.

References:

A-333

Hemodynamic changes after endotracheal intubation in patients with cerebral aneurysm (lightwand vs laryngoscope)

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Background and Goal of study: Tracheal intubation with a lightwand device will attenuate the hemodynamic stress response to tracheal intubation compared with direct laryngoscopy. So we compared the effects of the lightwand (lighted intubation stylet) and the laryngoscope (Macintosh blade) for intubation in patients with cerebral aneurysm.

Material and Methods: Twenty patients undergoing cerebral aneurysm clipping surgery were randomly divided to either the lightwand (Group 1, n = 13) or the laryngoscope (Group 2, n = 13) group. All patients received fentanyl (2–3 mg/kg), doxycortic (0.1 mg/kg) and thiopental sodium (5 mg/kg) followed by vecuronium (0.1–0.15 mg/kg). The lungs were ventilated with 3–4% isoflurane in oxygen. Patients were then intubated with either the lightwand or the laryngoscope. Systolic and diastolic blood pressures and heart rate were recorded continuously before and after intubation. And the time to intubation was recorded.

Results: There was no difference in hemodynamic changes between the two groups. Major factors of hemodynamic changes likely associated with direct tracheal stimulation.

Conclusion: We found that there was no difference in hemodynamic changes between the two techniques in patients with cerebral aneurysm.

Reference:

A-334

Antithrombin III concentrates reduce secondary brain damage in experimental model

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Background and Goal of Study: In addition to the well known role in blood coagulation cascade, thrombin contributes to generate the inflammatory response (induces chemokinesis, increases the expression of interleukins), and can be considered neurotoxic (determines the degeneration of neurons1, enhances brain edema2). In ischemic stroke patients the activation of coagulation cascade reflects on the increase of thrombin activity3 and on the consumption of the natural anticoagulant ATIII, with the consequent decrease of plasmatic levels4.

The aim of this study was to demonstrate the neuroprotective effects of AT III.

Materials and Methods: 16 mice underwent transient MCA occlusion. Group 1 (n = 6) and Group 2 (n = 6) were treated with AT III respectively 3–6 hours and 6–9 hours after the onset of ischemia, while Group 3 (n = 6) was treated with vehicle.

The mice were sacrificed 24 hours after the ischemia, the brain was removed, the slices colored with 2% TTC to discriminate the vital zones from the ischemic areas. T-test was used for statistical analysis.

Results and Discussions:

<table>
<thead>
<tr>
<th>Group</th>
<th>Ischemic areas Mean T</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>21.71 ± 16 mm²</td>
</tr>
<tr>
<td>2</td>
<td>42.26 ± 47 mm²</td>
</tr>
<tr>
<td>3</td>
<td>51.81 ± 25 mm²</td>
</tr>
</tbody>
</table>

AT III significantly reduces the infarct size area (p < 0.05) when injected 3–6 h after the onset of ischemia.

Conclusion: AT III may attenuate the secondary brain damage.

References:

A-335

Determination of critical cerebral perfusion pressure in cranial hypertension

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Background and Goal of study: A consensus has been reached that a cerebral perfusion pressure (CPP) of around 70 mmHg may provide an optimal blood supply to the brain. The aim of the present study was to measure the changes of energy-related metabolites in the porcine cortex during a defined increase of intracranial pressure (ICP), compare them with perfusion parameters and to determine the level at which damage occurs.

Material and Methods: Male domestic pigs (32–42 kg) were anaesthetised, mechanically ventilated, and randomly assigned to either the experimental (n = 6) or control groups (n = 5). A microdialysis probe (CMA 70) was inserted into the cortex and continuously perfused at a flow rate of 2 μl/min. Extracellular dialysate concentrations of lactate, pyruvate, glucose, glutamate and glycercol were measured from samples collected over 20 minute intervals during the whole experiment. Every hour a stepwise increase of 10 mmHg in ICP was produced by infusion of artificial cerebrospinal fluid into the ventricular system of the brain until maximum ICP of 50 mmHg was reached. In the control group no changes in ICP were made.

Results and Discussion: The present study demonstrated a significant increase of lactate and glycrol compared to control at ICP values ≥30 mmHg and CPP below 50 mmHg (2.33 ± 0.33 mmol/l (mean ± sem) vs. 1.21 ± 0.18 mmol/l and 124.64 ± 13.51 mmol/l vs. 73.19 ± 6.56 mmol/l, respectively). The elevation of ICP to 40 mmHg or more in conjunction with a reduction in CPP below 40 mmHg led to a significant increase in the lactate/pyruvate ratio and glutamate, as well as a decrease of glucose in relation to control (74.16 ± 16.53 mmol/l vs. 23.78 ± 2.08 mmol/l, 20.40 ± 6.14 μmol/l vs. 6.54 ± 3.28 μmol/l and 0.29 ± 0.11 mmol/l vs. 0.89 ± 0.19 mmol/l, respectively). There were no differences in blood glucose and lactate levels, in pH, PO2 and P02 detectable between the groups. It seems that the point of irreversible damage could be found where L/P ratio, glutamate and glycrol are significantly increased.

Conclusion: Our data strongly suggest that during a quick ICP increase, lower CPP values may be tolerable until severe damage occurs. In this model critical CPP values of 40–50 mmHg could be postulated.

Reference:

A-336

Hemodynamic responses to noxious stimulation during brain tumor surgery comparing remifentanil to sufentanil

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Introduction: During craniotomy, it is desirable to have stable, easily controllable hemodynamics. Remifentanil is a rapid, ultra-short-acting opioid that has been successfully used to control acute autonomic responses. In the present study, we compared the hemodynamic reactions to noxious stimulation in a remifentanil-based anesthesia to a sufentanil-based anesthesia.

Materials and Methods: With IRB approval, 30 patients (pts) scheduled for brain tumor surgery were randomized to sufentanil or remifentanil. Anesthesia was induced with propofol TCI (3 μg/ml), rocuronium (0.6 mg/kg), sufentanil TCI (0.4 ng/ml) or remifentanil TCI (10 ng/ml). Propofol was titrated to Bis 40 to 60, while analgesia was titrated to hemodynamic responses (20% of baseline). Mean arterial pressure (MAP), heartrate (HR) and Bis were analysed at intubation, pin holder placement, skin incision and at time of craniectomy. Statistical analysis was performed with Anova.

Results: At intubation, no patient experienced a significant increase in MAP. 4 pts in the remifentanil group (Rg) showed a significant decrease in MAP. Bis values in the sufentanil (Sg) group were lower at intubation than in the Rg. In both groups, 2 pts had a significant increase in HR at intubation. At pin holder placement, 2 Sg pts and 3 Rg pts experienced a significant increase in MAP and HR. We found no correlation between change in hemodynamics and Bis. Significantly more patients in the Rg necessitated titration of the analgetic component during or after intubation and pin holder placement. At skin incision and at time of craniectomy, we did not observe a significant increase in MAP or HR, nor in the Sg, nor in the Rg. Overall, there was no difference between both groups for the propofol requirements, although patients in the Rg required significantly more adjustments of the propofol TCI administration.

Conclusion: Sufentanil offers similar hemodynamic conditions, with less need for titration compared to remifentanil, for neurosurgical procedures.
A-337
Validation of an integrated model of cerebral haemodynamics and metabolism
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Background and Goal of Study: Computational modelling may be used to investigate and demonstrate complex, non-linear processes of cerebral haemodynamics and metabolism, but most models have concentrated on single aspects of physiology in isolation. (1) We have created and validated an integrated model describing intracranial haemodynamics and metabolism from large vessel to capillary and tissue level.

Materials and Methods: The model consists of sequential beds of parallel vessels contained within a non-compliant space containing brain, blood and cerebrospinal fluid (CSF). Individual vessels have defined volume, radius and compliance relationship, and flow is modelled as laminar throughout. Arteriolar wall tension is responsive to changes in CSF pH, transmural pressure and cerebral blood flow. Oxygen and carbon dioxide flux occur at the capillary level, taking into account the effect of tissue volume, pH and metabolic rate. The results of the computational simulation have been compared to published human data. Dynamic testing was performed by assessing steady-state change cerebral blood flow at various levels of mean arterial pressure and arterial carbon dioxide partial pressure (PaCO₂). To test dynamic autoregulation, a transient hyperaemic response to carotid occlusion was simulated and the strength of autoregulation (SA) calculated.

Results and Discussions: Vessel radii and compartment volumes are within published ranges. The upper and lower limits of autoregulation are mean arterial pressures of 60 and 150 mmHg. The calculated SA was 1.05 between the limits of autoregulation (normal range 0.88–1.13). Carbon dioxide reactivity is 40% kPa⁻¹ when PaCO₂ is 2–10 kPa. Brain tissue PO₂ varies between 3.5–4 kPa depending on distance from the capillary. Jugular venous haemoglobin oxygen saturation is 60–70% for arterial saturations 90–100%. The model appears to simulate normal physiology acceptably well under static and dynamic conditions.

Conclusions: This model provides a credible simulation of healthy, intracranial physiology. Further work will involve validation of the model under pathological conditions.

References:
1. PNAS 2001;98:6859-64.

A-338
Behaviour of IL18 in subarachnoid haemorrhage
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Background: Secondary brain injury due to systemic inflammatory response syndrome is a major factor contributing to morbidity and mortality. Subarachnoid haemorrhage is associated with elevated pro-inflammatory cytokines (1). IL18 has been shown to play an important role in many human diseases and it may be a marker of cerebral injury (2). The behaviour of IL18 in patients with subarachnoid haemorrhage is not known.

Method: With Local Research Ethics Committee Review and written informed consent, we recruited 10 patients with post-aneurysm subarachnoid haemorrhage, having embolisation of their aneurysm to a pilot study. We measured IL18 in blood samples taken pre and immediately postoperatively and at 24 and 48 h postoperatively. Clinical progress was noted using World Federation Neurological Scoring (WFNS). Statistical analysis used paired t-test with Bonferroni correction for multiple testing. Normal serum IL18 levels are mean(SD) 128(44), pg/ml⁻¹.

Results: Perioperative IL18 level. Data are mean (SD) [range]

<table>
<thead>
<tr>
<th></th>
<th>Pre-op</th>
<th>Post-op</th>
<th>24 hr</th>
<th>48 hr</th>
</tr>
</thead>
<tbody>
<tr>
<td>IL18</td>
<td>174 (78)</td>
<td>227 (87)</td>
<td>191 (91)</td>
<td></td>
</tr>
<tr>
<td>[100-365]</td>
<td>[85-330]</td>
<td>[100-312]</td>
<td>[95-352]</td>
<td></td>
</tr>
</tbody>
</table>

P < 0.0166 compared to preoperative level. The correlation between IL18 and WFNS was poor.

Conclusion: Immediate post-op IL18 levels were significantly raised as compared to pre-op. Greater numbers of patients are needed to investigate the behaviour of this cytokines and its association with cerebral dysfunction.

References:

A-339
Propofol effect on H-reflex recovery in humans
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Background and Goal of Study: The spinal H-reflex has been proposed for investigating immobilizing effects of anaesthetics. Its amplitude is suppressed in a dose dependent manner by propofol in humans and rats. A paired pulse stimulation was used to examine whether use-dependent block might play a role in H-reflex suppression during propofol anesthesia in the intact human spinal cord. Use dependent block, an increasing reduction of currents elicited by subsequent pulses applied at high frequency, can be explained by binding of propofol to ion channels such as Na⁺(1) and Ca²⁺ channels.

Materials and Methods: Following IRB approval and written informed consent, the study was performed in 16 patients prior to elective surgery. After recording baseline values, patients received propofol via a TCI-system with plasma concentrations corresponding to the C50 (electrical tetanus), approx. 4.5 mg/l. The H-reflex was recorded over the M. soleus after double-pulse stimulation (H1,H2) of the tibial nerve with increasing inter stimulus intervals (ISI) (50–1000 ms). Statistics: Amplitude ratios (H2/H1) compared by two way ANOVA; Bonferroni post test.

Results and Discussions: The presented time course of the H-reflex of all 16 patients shows a slower recovery under propofol in comparison to the control values. Significant differences occur only at an ISI of 150 and 200 ms. ISI dependent excitation of different sizes of Ia afferent fibres is discussed as an underlying mechanism for the intercurrent facilitation showing a maximum at 200 ms which is suppressed by propofol.

A-340
Nefopam or clonidine in the pharmacologic prevention of shivering in patients undergoing conscious sedation for interventional neuroradiology
Department of Anesthesiology, Charti Campus Mitte, Berlin, Germany

Background and Goal of Study: The spinal H-reflex has been proposed for investigating immobilizing effects of anaesthetics. Its amplitude is suppressed in a dose dependent manner by propofol in humans and rats. A paired pulse stimulation was used to examine whether use-dependent block might play a role in H-reflex suppression during propofol anesthesia in the intact human spinal cord. Use dependent block, an increasing reduction of currents elicited by subsequent pulses applied at high frequency, can be explained by binding of propofol to ion channels such as Na⁺(1) and Ca²⁺ channels.

Materials and Methods: Following IRB approval and written informed consent, the study was performed in 16 patients prior to elective surgery. After recording baseline values, patients received propofol via a TCI-system with plasma concentrations corresponding to the C50 (electrical tetanus), approx. 4.5 mg/l. The H-reflex was recorded over the M. soleus after double-pulse stimulation (H1,H2) of the tibial nerve with increasing inter stimulus intervals (ISI) (50–1000 ms). Statistics: Amplitude ratios (H2/H1) compared by two way ANOVA; Bonferroni post test.

Results and Discussions: The presented time course of the H-reflex of all 16 patients shows a slower recovery under propofol in comparison to the control values. Significant differences occur only at an ISI of 150 and 200 ms. ISI dependent excitation of different sizes of Ia afferent fibres is discussed as an underlying mechanism for the intercurrent facilitation showing a maximum at 200 ms which is suppressed by propofol.

References:
systemic energy demands, increased oxygen consumption and carbon dioxide production, and increased cardiac workload. **Materials and Methods:** A total of 128 patients were prospectively enrolled and assigned by a computer-derived sequence to one of 3 groups: 42 patients received 0.15 mg kg\(^{-1}\) of i.v. nefopam, in 10 ml of saline solution, 46 patients received 3 mcg kg\(^{-1}\) of i.v. clonidine in 10 ml of saline solution, and a control group of 40 patients received 10 ml of i.v. saline solution. Mean arterial pressure was kept at 100 mmHg or higher, the need for vasoactive drugs in the 3 groups of study patients was recorded. **Results and Discussions:** The overall incidence of intraoperative shivering was significantly lower in patients treated with nefopam than in those treated with clonidine or placebo (5% vs 26%; \(P < 0.05\) and 5% vs 62%; \(P < 0.01\); and in patients treated with clonidine than in those treated with placebo (26% vs 62%; \(P < 0.05\)). In the group of patients enrolled to receive clonidine as antishivering drug a larger number of patients required ephephrine infusion, to ensure a MAP of 100 mmHg or higher, in comparison to patients who received nefopam or placebo (45% vs 14%; \(P < 0.05\), 45% vs 10%; \(P < 0.05\)). We found that both nefopam and clonidine significantly lowered the rate and severity of shivering during interventional neuroradiologic procedures. **Conclusions:** Our findings in this double-blind prospective study suggest that nefopam is effective and has few disadvantages for the prevention of shivering during anesthesia or sedation in patients undergoing interventional neuroradiology. Unlike clonidine, nefopam has the distinct advantage of reducing the need for vasoactive drugs.

**A-341**

The effect of thalidomide on spinal cord ischemia/reperfusion injury in rabbits

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**Background and Goal of Study:** Thalidomide has anti-inflammatory and immunomodulatory effects through reduced production of TNF-\(\alpha\) [1]. The purpose of our study was to evaluate the effects of thalidomide on the spinal ischemia/reperfusion injury through reduced production of TNF-\(\alpha\).

**Material and Methods:** A rabbit spinal cord ischemia was induced by occluding infrarenal aorta for 15 minutes. The rabbits in group N (n = 6) did not undergo ischemic insult. The rabbits in group I (n = 18), group TI (n = 18), and group TIT (n = 12) underwent ischemic insult for 15 minutes. The rabbits in the group TI and TIT received thalidomide (20 mg/kg) intraperitoneally before the ischemic insult and the rabbits in the group TIT received thalidomide (20 mg/kg) 24 and 48 hours after reperfusion. After evaluating neurologic function at 1.5 hours, 3 days, and 5 days after reperfusion, the rabbits were killed for histopathologic evaluation and Western analysis for TNF-\(\alpha\).

**Results and Discussion:** The rabbits in the group TI and TIT showed significantly less neurologic dysfunction compared to those in the group I (\(P < 0.05\)). The number of normal spinal motor neurons in ventral gray matter was higher in the group TI and TIT than in the group I (\(P < 0.05\)). The Western analysis showed significantly increased level of TNF-\(\alpha\) in the group I compared to the group TI and TIT at 1.5 hours after reperfusion (\(P < 0.05\)).

**Conclusion:** The results indicate that treatment of thalidomide before the ischemic insult reduces the early phase ischemia/reperfusion injury of the spinal cord in the rabbits.

**Reference:**


**A-342**

Intraoperative motor evoked potential monitoring in scoliosis surgery – a randomised study comparing desflurane and total intravenous anaesthesia (propofol)

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**Background and Goal of Study:** During scoliosis surgery, monitoring motor evoked potentials (MEP) is used to assess intraoperative integrity of the motor evoked pathways. However MEPs are sensitive to the effects of inhalational anaesthetic agents. This prospective randomized observational study compares the use of desflurane and total intravenous agents (TIVA) when monitoring MEPs using multipulse cortical stimulation.

**Materials and Methods:** 20 consecutive patients undergoing scoliosis surgery (10 in each group) were randomly assigned to receive desflurane or TIVA. Inhalational anaesthesia was maintained using 66%N\(_2\)O in oxygen and mean end tidal desflurane concentration of 3.4%. For TIVA, continuous intravenous infusion of propofol was used. Fentanyl and morphine were used as required for analgesia for both groups. Cortical stimulation was achieved with the use of 2 bipolar direct current stimulators connected in parallel by jumper cables. 5 equivalent pulses 0.5 mm duration at 4 msec intervals were delivered at C1C2 positions MEP recordings were made at the abductor hallucis (AH) and tibialis anterior (TA) muscles with needle electrodes.

**Results and Discussions:** Reproducible MEPS were obtained throughout the operation in all 20 cases, with up to 80 mA per stimulator. Mean (SD) MEP amplitudes were observed were 85(19) mV and 210(18) mV for AH and TA respectively using desflurane. With TIVA AH and TA amplitudes were 56.7(28.4) and 59.1(24.5) mV respectively. Both muscle MEP amplitudes were significantly different using different anaesthetic regimes (\(P < 0.05\) for all four). AH MEP amplitudes obtained with desflurane were significantly (\(P < 0.0001\)) larger than TA amplitudes. No intra and post operative complications were reported.

**Conclusion(s):** This study compares the use of desflurane and TIVA showing that both anaesthetic regimes are satisfactory for intraoperative monitoring of the scoliosis patient.

**A-343**

Evaluation of desflurane and sevoflurane based anesthesia for supratentorial craniotomy procedures

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**Background and Goal of the Study:** Brain surgery necessitates stable and easily controllable haemodynamics, during intense surgical stimulation. Aim of the present study was to ascertain whether there is any difference between desflurane (Desf) or sevoflurane (Sevo) based anesthesia, employing remifentanil (R) as an opioid analgesic, with regard to haemodynamic performance during intracranial surgery.

**Materials and Methods:** We studied prospectively 56 adult patients (32 male/24 female, ASA I-II) scheduled for supratentorial craniotomy. After a standardized induction sequence consisting of propofol 2 mg/kg, lidocaine 1 mg/kg, cis-atracurium 0.2 mg/kg and remifentanil 0.5 mg/kg/min, followed by a constant-dose infusion of 0.125 mg/kg/min. When the MAP or heart rate (HR) increased >20% from basal values, 1 mg/kg bolus dose of R was administered. However, if the MAP or HR decreased >20% from basal values, the R infusion was transiently discontinued. Patients were allocated randomly to two groups of 28 each according to the inhalational agent used for maintenance of anesthesia: desflurane or sevoflurane (0.6–0.8 MAC) in an air/O\(_2\) mixture. BIS value <50 was used to assess depth of anesthesia and to guide inhalational anesthetic requirements. Total use of R was also recorded. For statistical purposes Mann-Whitney test and chi-square analysis were used as appropriate.

**Results:** Demographic characteristics, type of surgery and its duration and total dosages of R, were comparable in two groups. Data is given on the table.

<table>
<thead>
<tr>
<th>Parameters</th>
<th>Desf</th>
<th>Sevo</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>High BP (mmHg)</td>
<td>4 ± 6.2</td>
<td>2.7 ± 3.1</td>
<td>0.897</td>
</tr>
<tr>
<td>Low BP (mmHg)</td>
<td>5.2 ± 9</td>
<td>6.7 ± 12</td>
<td>0.633</td>
</tr>
<tr>
<td>High HR (bpm)</td>
<td>3.2 ± 6.1</td>
<td>1.1 ± 1.7</td>
<td>0.613</td>
</tr>
<tr>
<td>Low HR (bpm)</td>
<td>0.9 ± 2.4</td>
<td>3.2 ± 10</td>
<td>0.965</td>
</tr>
<tr>
<td>Bolus doses (%)</td>
<td>50%</td>
<td>50%</td>
<td>0.681</td>
</tr>
<tr>
<td>Discontinuation</td>
<td>25%</td>
<td>40%</td>
<td>0.437</td>
</tr>
<tr>
<td>Discontinuation (min)*</td>
<td>5.2 ± 9.9</td>
<td>11 ± 21.2</td>
<td>0.633</td>
</tr>
</tbody>
</table>

*mean ± SD.

**Conclusion:** Our results indicate that both desflurane/remifentanil and sevoflurane/remifentanil anesthetic techniques, appear to confer equal characteristics in maintaining “targeted” haemodynamic performance during intracranial surgery.

**A-345**

Atp-sensitive and voltage-dependent potassium channel involved in the antinoceptive effects produced by an adenosine A1 agonist into the brainstem medial pontine reticular formation in rats

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**Background and Goal of Study:** The brainstem medial pontine reticular formation (mPFR) is a brain stem region contributing to the regulation of

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sleep-wake cycles, anesthesia, and antinociception (1). Adenosine is thought to be an endogenous sleep promoting molecule and adenosinergic compounds play a key role in pain modulation (2). In the present study, we investigated the antinociceptive and behavioral effects of the direct application of an adenosine A1 receptor agonist R-(+)-N(6)-(2-phenylisopropyl)-adenosine (R-PIA) into the mPRF and examined the effects of potassium channel activation on antinociception of mPRF R-PIA in rats.

Materials and Methods: Sprague-Dawley rats were implanted with 24-gauge stainless steel guide cannulas in the mPRF. Animals were randomly assigned to one of the following protocols: antinociception was tested using a behavioral checklist. All measurements were performed after R-PIA microinjection into the mPRF with or without pretreatment of theophylline, DPCPX, glibenclamide, 4-AP.

Results: Data are presented as mean ± SD, statistical differences were analyzed using ANOVA followed by Bonferroni’s correction for post hoc comparisons. Microinjection of R-PIA (0.5-2.0 μg) into mPRF produced transient sedative effect and a significant dose- and time-dependent antinociception. The antinociception of R-PIA were completely antagonized by pretreatment with adenosine receptor antagonist theophylline or adenosine A1 receptor antagonist DPCPX, and partially antagonized by pretreatment with ATP-sensitive potassium channel blocker glibenclamide or voltage-dependent potassium channel blocker 4-AP.

Conclusions: The present results suggest that the R-PIA administered into the mPRF produced antinociception through pontine adenosine A1 receptor is mediated, at least partly, via the activation of both ATP-sensitive and voltage-dependent potassium channel in mPRF in rats.

References:

A-346

Modulation of H-current by calcium currents in rat sensory neurons: influence of spinal nerve ligation

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Background: Hyperpolarization-induced inward rectification and calcium currents both are major factors influencing excitability in primary sensory neurons [1]. Spinal nerve ligation (SNL) decreases both rectifying currents and membrane Ca2+ currents in rat dorsal root ganglion cells [1,2]. The direct relationship between Ca2+ currents and inwardly rectifying currents in DRG neurons has, however, never been investigated.

Materials and Methods: SNL or control operations were performed similarly to the previously described method of Kim and Chung (1992). DRG neurons were investigated using sharp microelectrodes. Time-dependent inward rectification (“sag”) in response to hyperpolarization was quantified during injection of a 1.2 nA hyperpolarization current for 100 ms.

Results: In our study, withdrawing external Ca2+ decreased the sag ratio in control Au/B neurons (from 18.9 ± 11.2% to 11.34 ± 10.6%, P < 0.01) and A/B neurons (from 14.06 ± 15.1 to 4.2 ± 10.9 %, P < 12, P = 0.05). Blocking Ca2+ currents using Cd2+ significantly decreased sag ratio in control cells (from 40.8 ± 11.4% to 30.1 ± 9.2%; P < 0.01, n = 5). The same effect was observed following intracellular EDTA iontophoresis (from 19.23 ± 17.2 to 14.9 ± 16.8%; P < 0.05, n = 5). SNL injury substantially precluded the effect of calcium withdrawal upon preentle change in sag ratio in both Au/B (7% vs. 27%) and A/B neurons (13% vs. 70%).

Conclusion(s): Our findings suggest that intracellular Ca2+ levels modulate hyperpolarization-induced rectifying current.

References:

A-347

Protecting effect of adrenaline and noradrenaline infusion during cerebral ischemia in rats

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Introduction: Katekolamin infusions are often used to protect hemodynamics in intracranial operations. The aim of this study is to observe the effects of adrenaline and noradrenaline in ischemia, provided by occlusion of middle cerebral artery (MCA).

Material and Methods: After approval of the animal ethic committee, 36 female Wistar rats separated into three groups randomly. After left arterial cannulation under anesthesia invasive hemodynamics followed up. Femoral venous cannulation was performed and 0.9% NaCl infusion was applied. All rats were ventilated during a tracheal cannula. After dissection of bilateral common carotid artery (CCA) 3 mg/kg l thiopental were applied intravenously. Hemodynamic parameters were recorded in every minute for 5 minute period. When SAP decreased by 20%, adrenaline or noradrenaline were given in a rate of 1–5 μg kg⁻¹ min⁻¹. When the rats that has no change in SAP values separated to control group. In control group 5 minute after thiopental application, in adrenaline and noradrenaline groups when SAP > 140 mmHg; left and right CCA and right external carotis artery (ECA) were ligated with a 3–0 silk suture. The MCA were occluded with internal occlusion catheter during internal carotis artery (ICA). For 60 minutes hemodynamic followed and at the end the rats were decapitated and their brains removed for pathological examination. The brains were sectioned and were examined. As parameter of the hypoxemia and ischemia, occurance of red neurons, microglial proliferation, vascular congestion, perineural vaculisation were assessed. For statistical analyses ANOVA and chi-square tests were used. P < 0.05 considered significant.

Results: Hemodynamic values were decreased in control group, but in all groups the SAP levels were over 120 mmHg.

<table>
<thead>
<tr>
<th>Vascular congestion</th>
<th>Perineural vaculisation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>None</td>
</tr>
<tr>
<td>C</td>
<td>0%</td>
</tr>
<tr>
<td>A</td>
<td>28%</td>
</tr>
<tr>
<td>NA</td>
<td>0%</td>
</tr>
</tbody>
</table>

P < 0.05

Conclusion: We conclude that ischemia can be prevented by adrenaline infusion in rats with MCA occlusion. This may be occured due to the increased effects of adrenaline on cerebral blood flow.

Reference:

A-348

Cellular mechanisms of inflammatory pain induced by low-frequency stimulation in the rat spinal cord in vivo

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Background and Goal of Study: Injection of formalin or capsaicin in the rat hind paw lead to low-frequency C-fibre activation are often used models for inflammatory pain. Here we have investigated whether low frequency discharges in C-fibres can induce synaptic long-term potentiation (LTP) of synaptic strength in primary afferent C-fibres in the rat lumbar spinal dorsal horn, a potential cellular mechanism of abnormal pain sensitivity.

Materials and Methods: C-fibre-evoked field potentials were recorded in laminae I/II of the lumbar spinal cord with glass microelecetodes. For conditioning stimulus either capsaicin (100 μl, 1% – 5% or formalin (100 μl, 5%, n – 6) was injected into the plantar side of the ipsilateral hind-paw, or low frequency stimulation (LFS; 60 V, 0.5 ms, 2 Hz for 2 min) was delivered to the sciatic nerve. To test if NK1-receptors are required for LTP-induction, the NK1-receptor antagonist RP67580 (10 mg/kg) was injected as a bolus intravenously 15 min prior to the induction of LFS. In other experiments, the NMDA-receptor antagonist MK 801 (3 mg/kg) was injected 15 min prior to the induction of LFS. The NO-synthase inhibitor L-NMMA (100 mg/kg) was given as a continuous infusion for 25 min starting 20 min prior to LFS.

Results and Discussion: Formalin or capsaicin induced LTP of C-fiber-evoked field potentials to 172 ± 9% (mean ± SEM) % or 174 ± 16%, respectively. LFS of the sciatic nerve induced LTP to 330% ± 42% of control (n = 14). The NK1-receptor-antagonist RP67580 diminished LFS induced LTP (LTP was to 248% ± 34%, n = 6). LFS-induced LTP is NMDA-receptor-dependent. When NMDA-receptor antagonist MK-801 was given prior to LFS, a short-term potentiation but no LTP was induced (n = 5). LFS-induced LTP is NK1-receptor-sensitive. The NO-synthase inhibitor L-NMMA given prior to the conditioning stimulus induced a short-term potentiation lasting for 60 min, but no LTP could be induced (n = 5).
Conclusions: Peripheral inflammation induces long-term potentiation of synaptic strength in superficial spinal dorsal horn. Low-frequency afferent stimulation in C-fibres is sufficient to induce LTP. This new form of synaptic plasticity is NMDA-and NK1-receptor-dependent and requires activation of NO-synthase.

A-349
A comparison of recovery following desflurane and sevoflurane anaesthesia in patients undergoing craniotomy for tumour
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Background and Goal of Study: Craniotomy for tumour carries the risk of postoperative complications such as bleeding, cerebral oedema and cerebral ischaemia. If not diagnosed early and treated promptly these can lead to neurological deficit. Therefore, rapid recovery and early neurological assessment are useful goals in the anaesthetic management of patients undergoing craniotomy for tumour.

The anaesthetic technique should enable a rapid and predictable recovery. The pharmacology of remifentanil and desflurane suggests that recovery will be faster if used in combination compared to remifentanil/sevoflurane anaesthesia. We compared recovery from remifentanil/desflurane vs remifentanil/sevoflurane anaesthesia in patients undergoing craniotomy for tumour.

Materials and Methods: 40 patients undergoing anaesthesia for elective craniotomy for tumour were randomly assigned to receive remifentanil/desflurane or remifentanil/sevoflurane anaesthesia. Following induction with remifentanil, propofol and rocuronium, anaesthesia was maintained with study vapour and remifentanil in oxygen and air. All treatment was standardised. Recovery staff blinded to the study recorded early recovery parameters.

Results and Discussions: The time required for spontaneous ventilation, eye opening, extubation, stating name, stating date of birth and achieving post anaesthesia recovery score (Aldrete) >9 were 50% shorter after remifentanil/desflurane compared to remifentanil/sevoflurane anaesthesia.

Conclusion(s): In patients undergoing craniotomy for tumour surgery, recovery is significantly faster and more predictable after remifentanil/desflurane compared to remifentanil/sevoflurane anaesthesia allowing a earlier neurological examination.

A-350
Endocrine stress response of remifentanil-based anaesthesia with isoflurane or propofol in craniotomy operations
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Background and Goal of Study: Surgical stress response and its prevention has been a currently popular research field (1). We aimed to examine effects of two anaesthesia techniques on stress response via plasma glucose (GLU), insulin (INS) and cortisol (COR) in craniotomy operations.

Materials and Methods: Forty patients scheduled for craniotomy were randomly divided into the injury group (I) three etomidate groups (E1, E2 and E3) with isoﬂurane (Group I) or propofol (Group II). GLU, INS, COR samples were obtained at time points as preoperatively (PRE), after intubation (INT) and dura incision (DUR), at 60th minutes (60.M) after extubation (EXT) and at postoperative 1st (P1) and 24th (P24) hour. Glucose measurements were also performed after induction, skull pin placement and craniotomy and at every 30 minutes during the procedure.

Results: All patients were comparable with respect to demographic properties. Glucose values measured after craniotomy, at 90th and 180th minutes were also statistically higher in the isoflurane group. Data (Mean ± SD) are shown in the table:

<table>
<thead>
<tr>
<th>GROUP I</th>
<th>GROUP II</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GLU</strong></td>
<td><strong>INS</strong></td>
</tr>
<tr>
<td>(mg/dL)</td>
<td>(μg/mL)</td>
</tr>
<tr>
<td>PRE</td>
<td>96.2 ± 16.5</td>
</tr>
<tr>
<td>INT</td>
<td>86.3 ± 10.6</td>
</tr>
<tr>
<td>DUR</td>
<td>104.8 ± 13.5</td>
</tr>
<tr>
<td>60.M</td>
<td>110.6 ± 17.0</td>
</tr>
<tr>
<td>EXT</td>
<td>122.7 ± 21.8</td>
</tr>
<tr>
<td>P1</td>
<td>134.9 ± 35.5</td>
</tr>
<tr>
<td>P24</td>
<td>117.6 ± 26.5</td>
</tr>
</tbody>
</table>

*p < 0.05; comparison with preoperative value within group; **p < 0.05: between groups.

Conclusion: Despite both anaesthesia techniques inhibited the rise in cortisol concentration during the procedure by a comparable degree, propofol anaesthesia was considered to be superior to isoflurane which was insufficient to prevent the increase in plasma glucose and the decrease in insulin level.

Reference:

A-351
Emergence after sufentanil-propofol TCI anaesthesia compared to remifentanil-propofol TCI for elective craniotomy
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Introduction: Early assessment of neurological function is essential after craniotomy. Remifentanil offers pharmacokinetic properties that might allow faster recovery after neurosurgery. Recently, it was reported that sufentanil TCI (with 0.25 ng/ml effect-site concentration at extubation) resulted in better recovery conditions that remifentanil TCI, at least for major abdominal surgery (1). In the present study, we compared the characteristics of recovery after sufentanil TCI and remifentanil TCI – combined with propofol TCI – for elective craniotomy.

Materials and Methods: With IRB approval, 20 pts scheduled for brain tumor surgery were randomized to sufentanil or remifentanil. Anaesthesia was induced with propofol TCI (3 μg/ml), rocuronium (0.6 mg/kg) and either sufentanil TCI (0.4 ng/ml) or remifentanil TCI (10 ng/ml). Propofol was titrated to maintain BIS values between 40 and 60, while the analgetic component (remifentanil or sufentanil) was titrated to automatic responses. Recovery times were taken from cessation of propofol infusion. In the remifentanil group, 1 hour before the anticipated end of surgery, pritramide 0.15 mg/kg was administered i.v. In the sufentanil group, an effect-site concentration of 0.25 ng/ml was targeted at extubation. Statistical analysis was performed with ANOVA.

Results: Although non significantly different, the mean time to eye opening tended to be shorter in the remifentanil group (11.1 min vs 17.1 min for sufentanil). Mean arterial blood pressure during the first postoperative hour was significantly increased in the remifentanil group compared to the sufentanil group. Therefore, significantly more patients required antihypertensive treatment in the remifentanil group. Patients in the remifentanil group required significantly more analgesics during the first postoperative hour. We did not observe a difference in respiratory rate or in arterial CO2-tension in the early post-extubation period between both groups.

Conclusions: Remifentanil TCI resulted in a nonsignificant shorter recovery time, but was associated a higher incidence of arterial hypertension and with less early postoperative pain relief. Sufentanil TCI offered superior and safe recovery conditions.

Reference:

A-352
Neuroprotective effects of etomidate on H2O2 induced injury in neuronal PC12 cells
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Background and Goals: To investigate the effect of etomidate to intracellular free calcium ([Ca2+]i) concentration change in response the H2O2-induced injury on the neuronal PC12 cells.

Materials and Methods: PC12 pheochromocytoma cell line were plated in 20 mm diameter cell culture dishes with density of 2 × 10⁶ cell/each and randomly divided into the injury group (I) three etomidate groups (E1, E2 and E3) with different concentrations 3 μM,1 and μM and 15 μM. The intracellular calcium concentration ([Ca2+]i) changes were continuously measured by the confocal laser scanning microscope after using the calcium day Fluo3 30 min in 37°C incubation and induced by the H2O2 in each group from the third scanning.

Results: The fluorescence of 90% PC12 cells increased immediately after H₂O₂ -induced injury (p < 0.05) and reached significantly changes at 10 min and gone to the top at 80 min in group I. Only the fluorescence of 10% PC12 cells of each group E were fluctuated and decreased lightly in group E; and E1 (p < 0.05) after 50 min.
Local and Regional Anaesthesia

A-356

Comparison of hyperbaric solutions of levobupivacaine and ropivacaine for spinal anaesthesia

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Background and Goal of Study: According to our previous observation hyperbaric levobupivacaine (in glucose 8%) provides more reliable spinal anaesthesia, with faster onset than the same dose of glucose free local anesthetic solution (1). The aim of this study was to compare the clinical efficacy of hyperbaric solutions of levobupivacaine and ropivacaine, when administered intrathecally.

Materials and Methods: Following institutional approval, we conducted a prospective, randomized, double blind study, including 60 men ASA status I–II, scheduled for transurethral procedures under spinal anaesthesia. They received levobupivacaine (group L) or ropivacaine (group R) 5 mg ml⁻¹ (with glucose 80 mg ml⁻¹), 3 ml from each anesthetic solution, injected into the L3–4 interspace. Sensory (pinprick) and motor block (Bromage scale 0–3) characteristics were recorded. Data were analyzed by median, χ² and Mann-Whitney U tests, p < 0.05.

Results and Discussions: Intergroup demographics were similar. All spinals were sufficient for the planned surgery.

Table. Results of spinal block characteristics.

<table>
<thead>
<tr>
<th>L (n = 30)</th>
<th>R (n = 30)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>† max. height (dermatome)</td>
<td>T7 (55–T11)</td>
<td>T8 (66–T11)</td>
</tr>
<tr>
<td>† min. to onset at T10</td>
<td>7.54</td>
<td>9.13</td>
</tr>
<tr>
<td>† min. to onset at max. height</td>
<td>12.47</td>
<td>14.22</td>
</tr>
<tr>
<td>† duration at T10 (min.)</td>
<td>115.46</td>
<td>73.42</td>
</tr>
<tr>
<td>Patients with grade 3 motor block (%)</td>
<td>80</td>
<td>73</td>
</tr>
<tr>
<td>‡ total duration of motor block (min.)</td>
<td>189.47</td>
<td>108.21</td>
</tr>
</tbody>
</table>

NS: non significant, †: median (range), ‡: mean (SD).

References:

A-355

Dose-dependent effects of fentanyl and remifentanil on the electrical activity of primary murine frontal cortex networks in vitro

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Department of Anesthesiology and Intensive Therapy, University of Rostock, Rostock, Germany

Background and Goal of Study: Fentanyl and Remifentanil are agonists at the µ-opioid receptor. Lately activation of the NMDA-receptor by opioids was reported (1). We used primary murine frontal cortex networks on microelectrode arrays (MEAs) to study the electrophysiological effects of fentanyl and remifentanil.

Materials and Methods: Cells on coated MEAs (CNSIS, Denton, Texas) were incubated at 37°C with constant pH at 7.4 in a 10% CO2 atmosphere until ready for use. Neuronal activity was recorded with a 64 channel amplifier system (Plexon Inc., Dallas). Units were discriminated with a template matching algorithm, spike and burst data were analyzed offline. Effects of Ketamine (n = 6) and Propofol (n = 10) application to native activity and Ketamine application to NMDAonly (after blockage of all receptors except that of NMDA; n = 9) and BCC activity (after blockage of the GABA A receptor with bicuculline; n = 4) were recorded.

Results: Ketamine caused initial increase at 1 mM up to 117 ± 10% and 128 ± 24% for spike (SR; n = 2) and burst rates (SR; n = 2), followed by a significant decrease to 9 ± 6% (SR; p = 0.006) and 14 ± 10% (BR; p = 0.003), respectively. Under NMDA only conditions initial increase was less pronounced (SR 109 ± 4%, p = 0.04, BR 111 ± 6%, p = 0.08) followed by a more distinct drop at higher concentrations (SR 2.8 ± 1.5%, p = 3.8E−17; BR 0.5 ± 0.2%, p = 5.0E−11). Under BCC conditions first significant activity reduction showed at 1 μM (SR: 79.8 ± 3.5%, p = 0.01; BR: 74.2 ± 7.7%, p = 0.04) without complete loss of activity at 100 μM (SR: 10.0 ± 5.8%, p = 0.0008; BR: 11 ± 6%, p = 0.0007). Propofol decreased frontal cortex activity significantly at $2.24 μM (SR: 10.0 ± 5.8%, p = 0.0006; BR: 11 ± 6%, p = 0.0007). At 2.25 mM activity dramatically dropped (SR: 10.7 ± 5.0%, p = 9.7E−8; BR: 12.5 ± 6.2%, p = 6.0E−7). With increasing propofol concentration synchronicity and regularity of network activity decreased.

Conclusions: Ketamine and Propofol show significant dose-dependent reduction of murine frontal cortex activity. Ketamine acts not only at the NMDA receptor, since dose response curve was shifted and maximum effect was pronounced under NMDAonly conditions. The results under GABA A blocking conditions suggest that Ketamine effects are partly mediated through the GABA B receptor.

References:
A-357
Combined spinal and epidural anesthesia for lower extremity surgery: minimum dose of hyperbaric bupivacaine solution during spinal anesthesia for geriatric patients

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Background and Goals: The dose of bupivacaine to produce a T10 level is reported to be 10–14 mg, a T12 level is 8–12 mg (1). Previous work at XXIII Annual ESRA Congress has shown that when hypobaric bupivacaine is given in incremental doses, a total of 4 mg or less is sufficient to produce satisfactory spinal anesthesia for lower extremity surgery in 88% of geriatric patients. In this study, the minimum effective dose of hyperbaric bupivacaine for lower extremity surgery was determined in geriatric patients by using different doses of the drug.

Materials and Methods: Twenty-eight patients, aged 65–88 (mean 75.1 ± 7.0) years were studied. Surgical sites were knee in 25 cases, leg in 1 case, ankle in 1 case, foot in 1 case. Surgical procedures performed were knee arthroscopy in 18 cases, total knee arthroplasty in 7 cases, osteosynthesis in 1 case, removal of hardware in 1 case and tendon suture in 1 case. Four ml of 0.5% hyperbaric bupivacaine solution (20 mg) were diluted with 6 ml of 10% dextrose to produce a 0.2% hyperbaric local anesthetic solution (20 mg/10 ml – 2 mg/ml). A combined spinal/epidural needle was inserted at the L2–L3 interspace or distally with the patient lying on the affected side. Incremental amounts of bupivacaine, 2 mg by 2 mg, were injected until the T12–T10 level of spinal anesthesia was obtained. An epidural catheter was then placed and 1–2 ml of 2% lidocaine were injected as a test dose, followed by continuous infusion of 2% lidocaine at a rate of 0–10 ml/h.

Results: The required doses of bupivacaine were 4 mg in 24 cases, 6 mg in 4 cases, with the mean of (4.29 ± 0.71) mg.

Conclusion: This study shows that when hyperbaric bupivacaine is given in incremental doses of 2 mg, a total of 4 mg is usually sufficient to produce satisfactory anesthesia in again over 80% of geriatric patients (23/27 = 0.85) for lower extremity surgery. This lower dose minimizes the risk of spinal anesthesia. Prolonged surgery and postoperative pain can be controlled by the combined spinal/epidural approach.

Reference:

A-359
Treatment with ACE inhibition or ARA until the morning of surgery does not increase the rate of hypertensive events during the early phase of spinal anaesthesia

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Background and Goal of the Study: Previous data report no difference in blood pressure response after spinal anesthesia between patients under treatment with antiangensin converting enzyme inhibitors (ACEI) and controls (1). This observational study measures prospectively blood pressure decrease after spinal anesthesia in patients chronically treated with ACEI or angiotensin II-receptor-antagonists (ARA). We evaluated the effect of either maintaining these drugs until the morning of surgery or discontinuing them the day before.

Materials and Methods: Twenty-five patients (ASA II/III) with arterial hypertension under long-term treatment with ACEI or ARA were assigned, depending on the previous treatment, to the Day Before surgery group (DB, N = 11) or the Morning of Surgery group (MS, N = 14). They underwent orthopaedic (16), urological (6) and inguinal hernia repair (3) procedures. Hyperbaric bupivacaine 0.5% (12.4 ± 1.5 mg) was injected intrathecally at a low lumbar interspace. Systolic blood pressure (SBP) was measured during the first twenty minutes after the neuroaxial block. The main clinical variables examined were the presence of hypotension (SBP < 90 mmHg) and the amount of vasoactive drugs used.

Results and Discussion: Hypotensive values were found neither in the DB nor in the MS group during the first twenty minutes. Only one patient in the MS group needed ephedrine (p = 0.57). SBP decrease seems to be faster (p = 0.02) in the MS group. Data of SBP in mmHg (Mean ± SD) are shown in the Table:

<table>
<thead>
<tr>
<th>Group</th>
<th>Minutes after neuroaxial block</th>
</tr>
</thead>
<tbody>
<tr>
<td>DB</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>164 ± 17</td>
</tr>
<tr>
<td>MS</td>
<td>160 ± 21</td>
</tr>
</tbody>
</table>

* p < 0.05 vs DB group.

Conclusion: Treatment with ACEI or ARA until the morning of surgery does not further magnify the blood pressure decrease during the early phase of spinal anaesthesia and does not increase the rate of hypertensive events. These results do not support to maintain or to discontinue ACEI or ARA before spinal anesthesia. Patient status and the surgical procedures have to be evaluated before withdrawing these drugs.

Reference:

A-360
High incidence of post-dural puncture headache after spinal catheters in young adults

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Background and Goal of Study: In single-shot spinal anaesthesia (SPA) with smallatraumatic needles (Whitacre 27G) the risk of post-dural puncture headache (PDPH) was calculated to be 1.7% in a metaanalysis with parturients as being at the highest risk. On the other hand, in continuous spinal anaesthesia (CSA) the data on PDPH is controversial, ranging from very low to over 30%. Since no prospective studies for the population of the young adults have been reported, we examined the development of PDPH in 3 small-gaual spinal catheter systems.

Materials and Methods: After ethic-committee approval 28 healthy volunteers (18–30 years old) received a spinal catheter (MicroCatheter, Portex, UK, n = 9; 22-G Spinalocath, n = 9 or 24-G Spinalocath, B.Braun, Germany, n = 10) at the lumbar level 3/4 or 4/5. The persons were enrolled in a neu-roendocrine investigation with intermittent sampling of serum and cerebrospinal fluid (17 × 0.5 ml) for analysis of neuropeptides. After 4 h the spinal catheter was removed and the test persons immediately mobilized. The development of PDPH and the intensity of headache were documented prospectively by using a standardized headache assessment method with a numeric rating scale (NRS 0–10). Nonparametric tests were applied for statistical analysis.

Results and Discussions: The study revealed a high overall incidence of 68% PDPH. (MicroCatheter: 89% PDPH, 22G-Spinalocath: 67% PDPH, 24G-Spinalocath: 50% PDPH, p = 0.19). The average onset of PDPH was on the second day (range: day 1–day 5). The mean of the maximal headache intensity documented on the NRS by the persons affected was M = 6.3 ± 2.5 and the mean duration of PDPH was M = 4.5 ± 2.3 days. Intensity and duration of headache increased significantly with the MicroCatheter, Portex (p < 0.05 resp.).

Conclusion: Because of the strikingly high incidence of PDPH after small-gauge spinal catheters, this anaesthesiologic technique at its present level of development has to be avoided in the young adult population.

References:

A-361
Prospective randomized trial of incidence and severity of headache following lumbar puncture with an a-traumatic 22 G needle compared with traumatic 22 G needle

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Department of Anaesthesiology, Hematology, Neurology, Rambam Medical Center, Haifa, Israel

Background and Goal of Study: Lumbar puncture (LP) allows the collection of cerebrospinal fluid (CSF) for diagnostic procedures and the injection of chemotherapeutic agents directly into the nervous system. Post-lumbar puncture headache (PLPH) is the most prevalent reported complication post LP, occurring in 40–70% patients. Therefore, we prospectively analyzed the
ability of an a-traumatic needle, usually used for spinal anesthesia to reduce the incidence of PLPH compared with a traumatic, conventionally used needle.

Material and Methods: 79 patients aged 18 years, who were planned either for diagnostic or therapeutic LP as part of their clinical management, were prospectively randomized to undergo LP with traumatic Quincke, 22 Gauge, 90 mm; TSK, JAPAN (n = 35) versus a-traumatic Whitacre, 22 Gauge, 0.70 mm, 130 mm, Polymedic, E.C (n = 44) needle. Patients with thrombo- count lower than 50,000 × 10^3/L and those with abnormal fundoscopy/ head CT scan were excluded. The same experienced anesthesiologist, using the identical technique, performed all LPs. Patients were immobilized for one-hour bed rest after LP.

The indication for LP and procedure-related parameters (e.g.: CSF volume, number of attempts, interspaces level) were recorded. Patient's demographic data, medical history, medications, a history of chronic pain syndrome and daily consumption of caffeine containing drinks, were evaluated. A questionnaire, provided on days 2 and 7 following LP assessed the appearance of neurologic complications, local pain, PLPH and therapy required for these complications.

Results and Discussion: There were no statistically significant differences in demographic data, background illnesses, a history of previous pain syndrome and indication for LP between the two groups. The incidence of local pain at site of needle insertion and neurological complications post LP was slightly lower in the a-traumatic group (16% vs. 29%, p = 0.16). However, the incidence of PLPH was significantly higher in the traumatic needle group compared with the a-traumatic group (34% vs. 2.3%, p = 0.003).

Conclusions: Using a-traumatic 22 G needle for diagnostic and therapeutic LP is feasible, safe and significantly reduces the incidence of PLPH. Therefore, an extensive application of a-traumatic Whitacre needle for both diagnostic and therapeutic applications is recommended.

A-363

Minimal effective dose of spinal hyperbaric bupivacaine for adult anorectal surgery: a prospective, double-blinded, randomized study

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Background and Goals: To find minimal effective dose of spinal hyperbaric bupivacaine for anorectal surgery.

Materials and Methods: The study included 93 adult consecutive ASA 1–3 patients. Spinal anesthesia (SA) was performed in the sitting position at L3-4 or L4-5 with hyperbaric bupivacaine (Marcaine Spinal Heavy 0.5%) injected over 2 minutes: group 1 (n = 38) 1.5 ml, group 2 (n = 38) 1.0 ml, group 3 (n = 38) 0.5 ml. After sitting for 10 minutes surgery was started. Following variables were assessed: rate of success, level and duration of sensory and motor block, time to voiding and ambulation, complications, consumption of analgesics, quality of anaesthesia according to the patient and medical staff. ANOVA, post hoc Bonferroni, χ² and Kruskall-Wallis tests were used where appropriate.

Results: Groups were comparable in demographics. No case of failure was registered but 4 patients (10.5%) in the 3rd group received supplemental †/v fentanyl. Characteristics of SA are presented in the table, mean ± SD, no of cases (%), median (range), p < 0.05 significant:

<table>
<thead>
<tr>
<th>Group 1</th>
<th>Group 2</th>
<th>Group 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sens. block, dermatomes</td>
<td>10.4*</td>
<td>7.013</td>
</tr>
<tr>
<td>Motor block</td>
<td>-</td>
<td>2.2*</td>
</tr>
<tr>
<td>Duration (min) of sensory block</td>
<td>204.1</td>
<td>201.6</td>
</tr>
<tr>
<td>Motor block</td>
<td>-</td>
<td>-42.6*</td>
</tr>
<tr>
<td>Duration of motor block, min</td>
<td>0</td>
<td>32</td>
</tr>
<tr>
<td>Time to ambulate, min</td>
<td>4</td>
<td>112.9</td>
</tr>
</tbody>
</table>
| Quality of anaesthesia was rated as excellent by patient in group 1 in 58.8% (76.5% day 1 postop.) versus 94.7% (92.1) and 86.8% (97.4%) in cases of group 2 and 3; by the ward nurse 82.4, 100 and 97.4%, respectively (p < 0.05).

Conclusions: 1) minimal dose of spinal hyperbaric bupivacaine for anorectal surgery is 0.5 mg; 2) 7.5 mg produce excessive sensory and motor block with lower rates of quality.

A-364

Gender differences in the development of pruritus after intrathecal sufentanil

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Department of Anaesthesiology, H.S. Marcos, Braga, Portugal

Background and Goal of Study: Intra-thecal sufentanil has gained increased popularity for the last years as it allows the reduction of the doses of local anaesthetics and latency time necessary to achieve subarachnoid block (SAB). Furthermore it provides additional analgesia long past the reversal of block. Like other opioids intra-thecal sufentanil has secondary effects like nausea, vomiting, respiratory depression and pruritus. The incidence of pruritus is dependent on the dose (1) and individual susceptibility. Although the precise mechanism of opioid-associated pruritus is not known, it has been associated (2) with opioid receptors that are influenced by sexual steroids. We hypothesize that gender is a factor of susceptibility to the development of pruritus after SAB with sufentanil.

Conclusion: We conclude that 7.5 mg of 0.5% hyperbaric ropivacaine and 5 mg of 0.5% hyperbaric levobupivacaine provide adequate spinal block for outpatient knee arthroscopy, with a faster home discharge as compared to 7.5 mg of 0.5% hyperbaric levobupivacaine.
Materials and Methods: This is a prospective cohort study (n = 130). Patients 18 or older, ASA I or II were randomly selected for the study. Patients were submitted to SAB using 0.4%–0.6% bupivacaine/cm of height and 2.5 microgram sufentanil. We evaluated and recorded the development of pruritus every 20 min after the block until 120 min, as well as nausea, vomiting, deep sedation and hypoxia. Pruritus was classified into 4 categories: none, light, moderate, severe. Data was analysed using ANOVA.

Results and Discussions: Women have an increased susceptibility to the development of pruritus, which appeared earlier and more frequently than in men. Pregnant and pre-menopausal women have increased susceptibility although it did not reach statistical significance.

Conclusion(s): Our data shows that women are more prone to the development of pruritus after SAB with sufentanil. We propose that the mechanism underpinning this fact might be the hormonal milieu of sexual steroids in particular progesterone.

References:

A-365
The influence of the temperature of bupivacaine 0.5% used for lumbosacral spinal anaesthesia (Taylor's approach) on onset and extent of block
R.J. Litz, N. Reytan, O. Vicent, D. Wiessner, A.R. Heller, T. Koch
Department of Anaesthesiology, University Hospital, Dresden, Germany

Background and Goal of Study: Within a few minutes local anaesthetics for spinal anaesthesia equilibrate to cerebrospinal fluid temperature resulting in decreased baricity and, depending on the agent used, in hypobaric behaviour. This may result in unintended peak block height, unintended cephalad spread and hypotension or bradycardia especially following unplanned posture change. For the lumbosacral approach according to Taylor more stable hemodynamics and lower peak block height have been reported compared to traditional lumbar puncture. The purpose of this study was to compare onset of block, maximum level of sensory block (MLSB) and hemodynamics during spinal anaesthesia using Taylor’s approach with plain bupivacaine at different temperatures.

Materials and Methods: After institutional approval and written informed consent 49 men undergoing transurethral prostate resection in spinal anaesthesia were randomly assigned to 2 groups. Twenty mg of plain bupivacaine were injected within 30 sec at 24°C (group 24°C) or 37°C (group 37°C), respectively. MLSB (pin-prick), loss of temperature discrimination to cold saline (LOTD), and motor block (Bromage scale), as well as heart rate and blood pressure was assessed every 2 min during onset of block by an examiner blinded to bupivacaine temperature. Decrease in blood pressure >20% to baseline was treated with theodreanaline.

Results and Discussions: Patient characteristics and duration of surgery did not differ between groups. Onset of block was faster in group 37°C as was peak block height (see Table). There was a moderate decrease in heart rate and blood pressure within 60 min in both groups, not necessitating interventions.

<table>
<thead>
<tr>
<th></th>
<th>Group 24°C</th>
<th>Group 37°C</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bromage 1 [min]</td>
<td>6.5 ± 4.3</td>
<td>3.3 ± 2.9</td>
<td>0.004</td>
</tr>
<tr>
<td>Bromage 2 [min]</td>
<td>10.5 ± 6.6</td>
<td>6.1 ± 4.9</td>
<td>0.011</td>
</tr>
<tr>
<td>Bromage 3 [min]</td>
<td>18.1 ± 11.3</td>
<td>10.3 ± 5.6</td>
<td>0.006</td>
</tr>
<tr>
<td>MLSB [segments]</td>
<td>11.6 ± 2.1</td>
<td>13.3 ± 2.2</td>
<td>0.007</td>
</tr>
<tr>
<td>MLSB [min]</td>
<td>19.1 ± 11.3</td>
<td>13.0 ± 8.7</td>
<td>0.038</td>
</tr>
<tr>
<td>LOTD [segments]</td>
<td>12.5 ± 2.1</td>
<td>14.5 ± 2.1</td>
<td>0.006</td>
</tr>
<tr>
<td>LOTD [min]</td>
<td>16.8 ± 10.0</td>
<td>11.2 ± 6.7</td>
<td>0.019</td>
</tr>
</tbody>
</table>

Conclusion(s): Plain bupivacaine injected at body temperature resulted in a more rapid onset and a higher MLSB without increasing the risk of hypotension or bradycardia. This may decrease the risk of secondary cranial block extension during posture change.

A-366
Total intravenous anesthesia (T.I.V.A.) versus spinal block in minor urological operations
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Background and Goal of Study: Traditionally, general or regional anesthesia has been employed during minor urological operations, whereas a variety of drugs and techniques have been introduced into ambulatory anesthesia. We compared the advantage of early home readiness and the side effects of these anesthesia techniques.

Materials and Methods: 60 unpremedicated patients, ASA I-II (18–60 av. age), who underwent hydrocele and varicocele repair were randomly divided into two groups. Group A (30 patients) received TIVA with propofol, fentanyl 1.5 μg⁄kg and atracurium 0.2 mg⁄kg and placement of a laryngeal mask. Patients in Group B (30 patients) had spinal anaesthesia administered using a midline approach with a 26-G atrumatic needle at the level of the L2–3 or L3–4 intervertebral space with the patient in the sitting position. The subarachnoid injection contained hyperbaric bupivocaine 0.5%, 1 ml and xylocaine 2%, 1 ml. The extent of the block was assessed by using pinprick and a modified Bromage scale.

Results and Discussion: On questioning 18% of patients who underwent spinal anaesthesia reported a headache and 50% of these headaches were described as moderate or severe and lasted between 12 and 24 hours. The average anaesthesia and recovery room times were significantly shorter for patients given TIVA (25 vs 40 min) and (80 vs 180 min) for the spinal group. The characteristics and duration of surgery were recorded. Patients in TIVA group had a greater need for postoperative analgesia. The times for home readiness were longer in spinal group.

Conclusions: In urological diagnostics and therapy the spinal anesthesia has still its full right, is less toxic for the patient and has less severe complications. However, prerequisite the full assent and psychic guidance of the patient during the whole duration of the intervention, it provides as effective as the general anaesthesia which has the advantage of earlier home readiness.

A-367
Ketamine sedation during spinal anesthesia for arthroscopic knee surgery reduced the ischemia-reperfusion injury markers
Department of Anesthesiology and Reanimation, Hacettepe University, Ankara, Turkey

Background and Goals: We studied the effect of ketamine sedation on oxidative stress during arthroscopic knee surgery with tourniquet application by determining blood and tissue malonyldiadehyde and hypoxanthine levels.

Material and Methods: Thirty ASA I-II patients, undergoing arthroscopic knee surgery with tourniquet were randomly divided into two groups. After standard monitoring, spinal anaesthesia was induced with 12.5 mg bupivacaine in all patients. In ketamine group after midazolam 0.01 mg kg⁻¹ IV, ketamine was infused at a dose of 0.5 mg kg⁻¹ h⁻¹ until the end of the surgery. In control group the same amount of placebo infusion was started after midazolam administration. Ramsey Sedation Scale (RSS) was used for determining the sedation level. Venous blood and synovial membrane tissue samples were obtained before ketamine infusion, at the 30th min. of ischemia, and at 5 min. after tourniquet deflation for malonyldiadehyde (MDA) and Hypoxanthine (HPX) measurements.

Results: There were not any difference among to Demographical data (Table 1) Tissue MDA and HPX levels were significantly lower in the ketamine group than the control group following reperfusion. RSS scores were higher in ketamine group without any adverse effect.

Conclusion: As a conclusion, ketamine sedation attenuated lipid peroxidation markers in arthroscopic knee surgery with tourniquet application.

A-368
Intravenous administration of NMDA receptor antagonists to the patient under spinal anesthesia: ketamine or magnesium
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Department of Anesthesiology, Tokya University Medical Faculty, Edirne, Turkey

Background and Objective: NMDA receptor antagonists; ketamine and magnesium have deceeded postoperative pain scores and analgesic requirements

References:
A-369
Music decreases propofol requirement of the target-controlled infusion during spinal anaesthesia
X.W. Zhang, Y. Fang, Y.K. Tian
Department of Anesthesiology, Tongji Hospital, Wu Han, China

Background and Goal of Study: Perioperative music has been shown to decrease patient’s sedative requirement. However, most results were obtained in conscious or lightly sedated patients and few objective measures were used. This study was designed to confirm such efficacy of music in patients being sedated adequately during spinal anesthesia by using bispectral index (BIS) monitoring and the target-controlled infusion of propofol.

Materials and Methods: In this prospective, randomized, controlled study, 100 patients, mean age 42.3 ± 8.6 year and mean weight 61.6 ± 8.6 kg, undergoing hysterectomy were perioperatively exposed to music or no music. None of them had hearing impairment, drug abuse or psychiatric disorder. Intraoperatively, sedation was maintained at an OAA/S score of 3 by BIS monitoring and the target-controlled infusion of propofol. Music was provided by a tape recorder in the operating room. No music was heard in control patients. The tapes included music of various genres: classical, rock, and soothing music. Music was presented for 5 minutes before and after the injection of spinal anaesthesia.

Results: The onset time of sensorial blockade was significantly longer in the music group compared to the control group. The BIS values of the music group were lower than the control group throughout the surgery. The BIS values of the music group were significantly correlated with the BIS values of the control group during the same period (r = 0.583, P < 0.001).

Conclusion: We conclude that perioperative music may benefit adequately sedated patients undergoing hysterectomy with spinal anaesthesia by decreasing the need for intravenous anaesthetics.

A-370
A sedative effect induced by spinal anaesthesia: a comparison between young and elderly patients
Department of Anesthesiology, Nagasaki University, School of medicine, Nagasaki, Japan

Background and Goal of Study: Spinal anaesthesia has been reported to have a sedative effect, i.e., decreasing the need for intravenous anaesthetics (1-2). This study was designed to estimate the comparative efficacy of spinal sedation in young and elderly patients using Bispectral Index (BIS) monitor and Observer’s Assessment of Alertness/Sedation (OAA/S) Scale.

Materials and Methods: We studied 11 young patients (mean age 16 ± 1.8 year; range 15-18 years old) and 13 elderly patients (mean age 75.5 ± 4.7 year; range 70-84 years old) who received lower limb surgery under spinal anaesthesia. Patients received 13-16 mg of isobaric 0.5% bupivacaine intrathecally according to the surgical procedure requirements. A depth of sedation was evaluated using BIS monitoring and OAA/S scale before and 5–10 minutes interval after starting spinal anaesthesia. Statistical significance (P less than 0.05) was determined using paired t-test, unpaired t-test and repeated measure ANOVA.

Results and Discussions: We compared the economic aspects and anes- thesia costs of SA compared to GA (1). We evaluated the effects of chronic alcohol intake on propofol-induced sedation in spinal anaesthesia.

Materials and Methods: Study of patients with 20–50 years of age, scheduled for knee joint surgery, were enrolled. Alcohol Use Disorder Identification Test (AUDIT) questionnaire was used as a marker of alcohol consumption. Propofol infusion was titrated to maintain Bispectral index (BIS) in the range of 70–80 in a blinded manner.

A-371
Effects of chronic alcohol consumption on propofol-induced sedation in spinal anaesthesia
Department of Anesthesiology and Pain Medicine, Medical School, Chonnam National University, Gwangju, Republic of Korea

Background and Goal of Study: It has been known that anesthetic induction dose of propofol is increased in patient with chronic alcoholism (1). We evaluated the effects of chronic alcohol intake on propofol-induced sedation in spinal anaesthesia.

Materials and Methods: Twenty-one adult patients with 20–50 years of age, scheduled for knee joint surgery, were enrolled. Alcohol Use Disorder Identification Test (AUDIT) questionnaire was used as a marker of alcohol consumption (2). Propofol infusion was titrated to maintain Bispectral index (BIS) in the range of 70–80 in a blinded manner.

Results and Discussions: The infusion rates of propofol were between 2.56 and 7.02 mg/kg/hr and were correlated with AUDIT score significantly (Spearman, r = 0.583, P < 0.001).

Conclusion(s): A careful and judicious use of propofol is recommended in sedation for chronic alcoholic patients during regional anesthesia.

References:
Materials and Methods: Thirty patients undergoing elective hip or knee replacement were randomized to receive either GA or SA. We assessed the costs of all used resources (drugs, gas, fluids, medical items) and the clinical relevant times. Personnel costs were neglected. GA was induced by fentanyl and propofol. Intubation was facilitated by rocuronium. Anesthesia was provided by 1 MAC Sevoflurane in 1.5 liter fresh gas flow and by repeated dosages of fentanyl IV. SA was performed after skin infiltration with lidocaine 2% (2–5 ml) by single shot technique at the L2–3 or L3–4 interspace with a 26-Gauge needle. For sedation repeated doses of midazolam IV were given. Postoperative analgesia was standardized with paracetamol 1000 mg IV and additional piritramid 3 mg IV boluses. Discharge criteria from PACU were defined as Aldrete Score > 8. Statistical Analysis was done by t-test for independent samples.

Results and Discussion: Patients’ demography (age, sex, height, weight, ASA) and anesthesia relevant durations were similar in both groups. Costs per case were lower in the SA group (€ 43.06) compared to the GA group (€ 104.90; P < 0.01).

Conclusions: Whereas, for minor surgery the costs of SA and GA are similar (2, 3) we showed that SA is more cost-effective than GA in longer cases. We conclude, that SA is more cost-effective than GA in patients undergoing elective knee or hip replacement.

References:

A-373
The pharmacokinetic profile of a sustained-release formulation of bupivacaine (SKY0402) administered as a partial nerve block
G. Manvelian, C.F. Lihou, D.F.C. Gibson
Department of Clinical and Medical Affairs, SkyePharma Inc, San Diego, USA

Background and Goal of Study: SKY0402 is a sustained-release formulation of bupivacaine intended for the treatment of post-operative pain following perineural, epidural, subcutaneous, or intra-articular injection. In the current study, the pharmacokinetics of SKY0402 were compared with unencapsulated bupivacaine (UB) administered via a partial ankle nerve block.

Materials and Methods: This was a Phase 1, randomized, double-blind, dose-escalation study in which four cohorts of healthy male subjects were included. All were healthy, non-smokers without medication. Brachial plexus blockade using Bupivacain, Lidocain and Epinephrine was performed. Skin microcirculation was measured on the forearm using LDF before and after nerve blockade and wavelet transform was performed.

Results and Discussions: The five horizontal lines in the box plots show the median, quartiles and the 10th and 90th percentiles.

Conclusions: Brachial plexus blockade reduces the forth and fifth oscillation of the perfusion signal. These alterations in skin microcirculation induced by brachial plexus blockade are related to inhibition of sympathetic activity in the vessel wall and a possible effect on endothelial function.

Reference:

A-375
The distribution of injected solution in simulated paravertebral nerve block. An anatomical study
J. Malek, A. Kurzova, J. Sach, A. Srp, J. Rosina
Department of Anaesthesiology and Intensive Care, Charles University in Prague, 3rd Medical Faculty, Czech Republic

Background and Goal of Study: The paravertebral nerve block is used for various procedures. The aim of our study was to assess if there is a relationship between injected volume and intercostal nerve distribution.

Materials and Methods: After ethic committee approval a study was performed on 16 human cadavers. Ten, resp. 20 ml of methylene blue colored water were randomly administered on each side at T 4 level before section. A standard technique of paravertebral block was used. After removal of thoracic and abdominal organs the extent of color below pleura could be observed and the number of intercostal spaces was noticed.

Results and Discussions: The paravertebral space could not be detected from anatomical or technical reasons on the one or the other side in 4 cadavers. Results obtained in the other 12 cases are presented in Table 1. There was a clear relationship between the number of colored intercostal spaces and injected volume at the same individual (p < 0.05), but there was not found any relationship between the number of colored intercostal spaces and injected volume across the whole sample studied. It means that at the same body doubling the dose means roughly doubling the number of nerves influenced, but we were not able to predict how many intercostal nerves will be affected by a given volume.

Table 1. Number of colored intercostal spaces and injected volume in 12 cadavers.

<table>
<thead>
<tr>
<th>No</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 ml</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>20 ml</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>6</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>2</td>
</tr>
</tbody>
</table>

Conclusion(s): We were not able to predict an extent of spread of colored dye to the intercostal nerves in relationship to the administered volume in post mortem study. The impact for clinical praxis needs further examination.

A-377
Lipophilicity of local anaesthetics determines their effects on intracellular calcium regulation in skeletal muscle fibres
W. Zink, G. Missler, E. Martin, R. Fink, B. Graf
Department of Anaesthesiology, University of Heidelberg, Heidelberg, Germany

Background and Goal of Study: A massive increase in intracellular Ca^{2+} is considered to be major patho-mechanism in local anesthetic myotoxicity. 1
A-380

Epidural clonidine causes an increase in T-helper1 lymphocytes and a decrease in T-helper2 lymphocytes in patients undergoing lung surgery

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Department of Anaesthesiology and Perioperative Intensive Therapy, Clinical Center Ljubljana, Ljubljana, Slovenia

Background and Goal of Study: Surgical trauma initiates stress response in human body with consecutive immune suppression. Previous study established that clonidine modulates immune stress response at the end of operation (1). The goal of this study was to make clear the effects of clonidine on lymphocyte subsets in postoperative period.

Materials and Methods: In a prospective, double-blinded study 16 patients with lung carcinoma were randomly divided to two groups, clonidine (CLO; n = 8) and control (CON; n = 8). All patients received a bolus of 40 μg/kg of morphine by epidural catheter at TH10. The CLO also received 1 μg/kg of clonidine epidurally, before the induction to general anesthesia (GA). We used continuous epidural infusion of 4 μg/kg/h of morphine and 10 μg/kg/h of bupivacaine in saline for postoperative analgesia in both groups. In CLO we added 0.2 μg/kg/h of clonidine. We took four blood samples (before induction to GA – T1, at the end of operation – T2, the next morning – T3 and the second morning – T4) and measured lymphocyte subsets (CD3, CD4, CD8, CD19, CD16/56, IFNγ/CD4 (T-helper1), IL-4/CD4 (T-helper2)), using flow cytometry. We compared the significance of ratios of absolute counts of lymphocytes in certain subsets between two samplings using T-test.

Results and Discussions: Clonidine causes an increase in T-helper1 and a decrease in T-helper2 (Table 1, Table 2).

Table 1. Ratio of absolute count between T2 and T4

<table>
<thead>
<tr>
<th></th>
<th>T-helper 1</th>
<th>T-helper 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLO</td>
<td>1.35 ± 0.7</td>
<td>*p &lt; 0.05</td>
</tr>
<tr>
<td>CON</td>
<td>0.73 ± 0.37</td>
<td></td>
</tr>
</tbody>
</table>

There were no significant differences in other lymphocyte subsets. An increase in T-helper1 and a decrease in T-helper2 are beneficial for cancer patients since this favors cellular immune response.

Conclusion(s): Changes in immune response caused by clonidine after lung surgery may be advantageous for cancer patients.


A-379

Effect of carbamate local anaesthetics on NMDA receptors signaling: role of side chain position in lipophilic part

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Background and Goal of Study: Clinically used local anaesthetics, both amides and esters, inhibit NMDA receptor signaling in Xenopus oocytes (1). This effect seems to be independent on the linking bond in local anaesthetics molecule. To further evaluate the molecular structural features needed for this inhibition, we study the effect of experimental local anaesthetics with carbamate linking bond on recombantly expressed NMDA receptor (NR 1/2A) in Xenopus oocytes. We investigated the effect of heptacaine and its 2 geometric isomers (XX and XXI), which differ in the position of the side carbon chain on the aromatic ring. Lipid solubility and pKa of these compounds are almost same.

Materials and Methods: Human NR1/NR2A receptors were expressed in Xenopus laevis oocytes by microinjection of mRNA. Receptors were studied under voltage clamp, using Ba as charge carrier, and responses to the physiological co-agonists glutamate and glycine (G/G, both at 10−4 M) were determined in the absence and presence of heptacaine, XX and XXI (all at 10−4 M, incubation 10 min). Results are reported as % of control ± SEM, and were analyzed by t-test.

Results and Discussions: We observed no inhibition of NMDA receptor with heptacaine, in concentration 10−4 M (95.3% control response, p = 0.781); while its geometric isomers significantly inhibited signaling through NMDA receptor in this concentration (XX 64.6% control response, p < 0.05; XXI 68.7% control response, p < 0.05).

Conclusion(s): We observed inhibition of NMDA signaling in Xenopus oocyte model also by local anesthetic with carbamate linking bond; however this effect was strongly determined by the position of the substitution on aromatic ring. Significant inhibitory effect was observed only by the compounds with the alky chain in positions 3- and 4- on the aromatic ring; while heptacaine, with the bulky substitution in position 2- on the aromatic ring, was found to cause no significant inhibitory effect on NMDA signaling.

Reference: 1 Hahnenkamp K et al. Anaesthesiology 2004; 101: A897
Mean [SD], hours

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Group R18</th>
<th>Group R18,F</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sens. recovery (Pinprick – S2)</td>
<td>3.2 [0.8]</td>
<td>2.8 [0.6]</td>
<td>0.006</td>
</tr>
<tr>
<td>Motor recovery (Bromage = 0)</td>
<td>1.7 [0.6]</td>
<td>1.1 [0.6]</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Walking around the bed</td>
<td>3.1 [0.7]</td>
<td>2.8 [0.7]</td>
<td>0.017</td>
</tr>
<tr>
<td>First voluntary voiding</td>
<td>5.3 [1.4]</td>
<td>5.3 [1.6]</td>
<td>0.902</td>
</tr>
</tbody>
</table>

Conclusions: Earlier recovery (by means of pinprick sensory block, Bromage motor block, and ability to walk) was noticed in Lf. fentanyl 0.2 mg compared with hyperbaric bupivacaine 10 mg compared to Lf. hyperbaric ropi-
avcaine 15 mg for day-case surgery. As the latency to micturition was relatively long (5 h) and itching was bothersome, further focus on individualised adjustment of doses and their proportions is needed.

References:

A-382

The improvement in analgesic parameters of spinal anesthesia by the addition of intrathecal midazolam to bupivacaine in benign prostate hyperplasia surgery repair

E. Lykoudi, G. Garantouanakis, V. Theodoropoulos, E. Kapota, K. Alexandrioti, E. Chamilos, As. Kouta
Department of Anaesthesiology, Agia Olga General Hospital of N. Ionia, Athens, Greece

Background and Goal of the Study: Antinociceptive effect of midazolam is well established now and its safety is documented. This study compared the efficacy (peroperative and postoperative pain relief), safety and side effects with respect to recovery time, pain scores, patient satisfaction, dura-
tion and quality of regional anesthesia, by the administration of hyperbaric bupivacaine intrathecally either alone or with midazolam using spinal block-
ade for transvesical (TVPE) or transurethral (TURP) prostatectomy.

Materials and Methods: 60 patients, ASA I-III, with an average age of 70.7 years, scheduled to undergo TURP or TVPE for benign prostate hyperplasia (BPH) under spinal anesthesia, were enrolled in this prospective and ran-
donized trial. The patients were randomly allocated in two groups; Group A-385

A-385

Spinal diamorphine: a comparison of two doses for knee arthroplasty

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Department of Anaesthesia, Royal Bournemouth Hospital, Bournemouth, United Kingdom

Background and Goal of Study: Intra-thecal diamorphine (ITD) may delay the need for intravenous post-operative analgesia and reduce the total dose required. The optimum dose is unknown. The efficacy and side-effects of two doses of ITD were compared in this prospective trial.

Materials and Methods: We randomized 41 patients for unilateral primary knee arthroplasty to receive 0.5 mg or 1.0 mg ITD with 12.5 mg hyperbaric bupivacaine as spinal anaesthesia. Post-op analgesia was provided by mor-
phine in a patient-controlled analgesia (PCA) device. Time to first morphine dose (M) and total morphine dose (M) were recorded. Nausea and sedation scores (verbal rating scores 0–3), lowest respiratory rate and pruri-
tis needing treatment were also examined.

TT4 | DA | QA | PS | FART
---|---|---|---|---
BA | 10.00 | 146 | 100 | 100 | 104.1
BF | 10.48 | 146 | 100 | 100 | 109.4
BS | 13.20† | 120† | 60 | 66.7 | 89.47†

† TT4: time to reach T4 dermatome, DA: duration of anesthesia, QA: patient satisfaction, FART: first analgesic request time.
Results and Discussions:

<table>
<thead>
<tr>
<th>Dose of IT diamorphine</th>
<th>0.5mg</th>
<th>1mg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients</td>
<td>19</td>
<td>22</td>
</tr>
<tr>
<td>Age (y)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight (kg) * p&lt;0.08</td>
<td>65 (15)</td>
<td>94 (18)</td>
</tr>
<tr>
<td>M1 (mm) * p&lt;0.001</td>
<td>231 (87)</td>
<td>472 (171)</td>
</tr>
<tr>
<td>M1 (mm) * p&lt;0.001</td>
<td>58 (26)</td>
<td>29 (18)</td>
</tr>
<tr>
<td>Nausea score &gt; 2 (No pts)</td>
<td>4 (21%)</td>
<td>3 (14%)</td>
</tr>
<tr>
<td>Sedation score &gt; 2 (No pts)</td>
<td>0 (0%)</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Lowest resp rate &lt; 11 (No pts)</td>
<td>1 (5%)</td>
<td>3 (14%)</td>
</tr>
<tr>
<td>Significant pruritis (No pts)</td>
<td>1 (5%)</td>
<td>2 (9%)</td>
</tr>
</tbody>
</table>

*mean(sd).

Figure 1. “Survival curve” of time of first PCA request.

Conclusion: 1 mg ITD prolongs post-operative M1 and reduces M1 in knee arthroplasty compared to 0.5 mg.

Reference:

A-386

The effect of adding intrathecal magnesium sulphate to bupivacaine-fentanyl spinal anaesthesia

M. Ozalevli, T.O. Cetin, H. Ulugenc, T. Guler, G. Isik
Department of Anaesthesiology, Cukurova University, Adana, Turkey

Background: In this prospective, randomized, double-blind, controlled study, we investigated the effect of adding intrathecal magnesium sulphate to bupivacaine-fentanyl spinal anaesthesia.

Methods: 102 ASA I or II adult patients undergoing lower extremity surgery were recruited. They were randomly allocated to receive 1.0 mL of preservative-free 0.9% sodium chloride (group S) or 50 mg of magnesium sulphate 5% (1.0 ml) (group M) following 10 mg of bupivacaine 0.5% plus 25 mg of fentanyl intrathecally. We recorded the following: onset and duration of sensory block, the highest level of sensory block, the time to reach the highest dermatomal level of sensory block and to complete motor block recovery and the duration of spinal anaesthesia.

Results: Magnesium caused a delay in the onset of both sensory and motor blockade. The highest level of sensory block was significantly lower in group M than in group S at 5, 10 and 15 minutes (p < 0.001). The median time to reach the highest dermatomal level of sensory block was 17 min in group M and 13 min in group S (p < 0.05). The mean degree of motor block was also lower in group M at 5, 10 and 15 minutes (p < 0.001). The median duration of spinal anaesthesia was greater in group M (p < 0.001).

Conclusion: In patients undergoing lower extremity surgery, the addition of intrathecal magnesium sulphate (50mg) to spinal anaesthesia induced by bupivacaine and fentanyl significantly delayed the onset of both sensory and motor blockade, but also prolonged the period of analgesia without additional side-effects.

A-387

Intrathecal magnesium, fentanyl, or placebo combined with bupivacaine 0.5% for parturient undergoing elective cesarean delivery

Department of Anaesthesiology, Cukurova University, Adana, Turkey

Background: In this prospective, randomized, double-blind, controlled study, we investigated the sensory, motor, and analgesic block characteristics of intrathecal magnesium 50 mg compared with fentanyl 25 microgram and saline when added to 0.5% bupivacaine (10 mg).

Material and Methods: 90 ASA I or II adult patients undergoing cesarean section were recruited. They were randomly allocated to receive 50 mg of magnesium sulphate 5% (1.0 ml) in group M, 1.0 mL of 0.9% sodium chloride in group S or 25 microgram (1.0 ml) of fentanyl in group F following 10 mg of bupivacaine 0.5% intrathecally. We recorded the followings: onset and duration of sensory block, the highest level of sensory block, the time to reach the highest dermatomal level of sensory block, onset and duration of motor block, the quality and the duration of spinal analgesia.

Results and Discussion: Magnesium caused a delay in the onset of both sensory and motor blockade (p < 0.007). Duration of sensory and motor blockade was significantly longer in M group than in S group (p < 0.004). Time to reach the highest dermatomal level of sensory block was significantly shorter in group F than in S and M groups (p < 0.004). The quality of spinal analgesia was significantly better in group F compared with group M and S (p < 0.004). The duration of spinal analgesia was significantly greater in group F than in group S and M (p < 0.001), but there were no significant differences in mean pain and sedation scores at any time.

Conclusion: In patients undergoing cesarean section, the addition of intrathecal magnesium (50 mg) significantly delayed the onset of both sensory and motor blockade without causing any side-effect. However, the addition of intrathecal fentanyl (25 mg) plus spinal bupivacaine (10 mg) provided shorter onset and longest duration of effective analgesia.

Reference:

A-388

Intrathecal S(+) ketamine, fentanyl, or placebo combined with bupivacaine 0.5% for parturient undergoing elective cesarean delivery

Department of Anaesthesiology, Cukurova University, Adana, Turkey

Background: In this prospective, randomized, double-blind, controlled study, we investigated the sensory, motor, and analgesic block characteristics of intrathecal S(+) ketamine (0.05 mg kg⁻¹) compared with fentanyl 25 microgram and saline when added to 0.5% bupivacaine (10 mg).

Methods: 90 ASA I or II adult patients undergoing cesarean section were recruited. They were randomly allocated to receive 0.05 mg kg⁻¹ of S(+) ketamine (1.0 ml) in group K (n=30), 1.0 mL of 0.9% saline in group S (n=30) or 25 microgram (1.0 ml) of fentanyl in group F (n=30) following 10 mg of bupivacaine 0.5% intrathecally. We recorded the followings: onset and duration of sensory block, the highest level of sensory block, the time to reach the highest dermatomal level of sensory block, onset and duration of motor block, the quality and the duration of spinal analgesia.

Results: Onset times of motor and sensory block were similar between S(+) ketamine and fentanyl groups. Duration of sensory and motor block and spinal analgesia was shorter in K group than in F group (p < 0.05). Time to reach the highest dermatomal level of sensory block was significantly shorter in group K and F than in group S (p < 0.05). The quality of spinal analgesia was significantly better in group K and F than in group S (p < 0.05). No major complication was reported and mostly (hypotension, urinary retention, sedation) were minor.

Conclusion: Spinal anaesthesia provided by intrathecal S(+) ketamine (0.05 mg kg⁻¹) plus spinal bupivacaine (10 mg) is as effective and safe as that provided by intrathecal fentanyl (25 mg) plus bupivacaine (10 mg), with a faster recovery of sensory and motor block.

A-389

Comparison of the effects of the intrathecal levobupivacaine and levobupivacaine + fentanyl in patients undergoing TUR procedure

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Department of Anaesthesia and Reanimation, Gazi University School of Medicine, Ankara, Turkey

Background and Goal of Study: Intrathecal fentanyl increases the intensity of motor and sensorial block and prolongs the duration of block without...
prolonging recovery time when added to bupivacaine (1, 2). Intrathecal levobupivacaine has also similar properties with less toxic effects. The aim of this study is to compare the effects of intrathecal levobupivacaine combined with different doses of fentanyl.

**Materials and Methods:** 60 ASA I–II patients who were scheduled for TUR procedure were included in this double-blind, randomised study after the approval of ethics committee. Patients were allocated into 3 groups and levobupivacaine 10 mg, levobupivacaine 10 mg + fentanyl 12.5 mg, levobupivacaine 10 mg + fentanyl 25 mg were administered in groups I (n = 20), II (n = 20) and III (n = 20) respectively. SAP, DAP, MAP, HR, SPO2, level of sensorial and motor block were recorded at 0, 3, 5, 7, 10, 15, 20, 25, 30, 45, 60, 75, 90, 105, 120 minutes. Level of motor block was recorded in 30 minutes and group B received bilateral GNB using 0.75% ropivacaine and 0.5% bupivacaine with adrenaline 1:200 000 at the end of operation respectively. Adverse effects were assessed.

**Results:** Demographic data, SAP, DAP, MAP, HR, SPO2 were similar in all groups. Sensorial block reached to T10 faster in group I than in group III (p < 0.05). 2 segment regression time was significantly shorter in group I than in group III (p < 0.05). Complete resolving time of motor block was longer in groups II and III than in group I (p < 0.05). Adverse effects were also similar in both groups.

**Conclusion(s):** Intrathecal 25 mg fentanyl when added to levobupivacaine produces early sensorial block, and prolongs the duration of sensorial and motor block. Therefore we think further studies should be performed with low doses of levobupivacaine in patients undergoing TUR procedure under spinal anaesthesia.

**References:**

### A-390

**The effect of glossopharyngeal nerve block with ropivacaine on immediate postoperative pain relief after tonsillectomy in adult patients**

Y.T. Jeon, H.P. Park, J.H. Kim, J.M. Kang, Y.S. Oh

Department of Anesthesiology and Pain Medicine, Seoul National University Bundang Hospital, Seong-Nam, Republic of Korea

**Background and Goal of Study:** Post-operative pain is the common problem following tonsillectomy. This prospective randomized study was designed to assess the effect of the glossopharyngeal nerve block (GNB) with ropivacaine on throat pain after tonsillectomy in adult patients.

**Materials and Methods:** 45 patients were allocated randomly to one of three groups. Group C had no further intervention until recovery. Group R and group B received bilateral GNB using 0.75% ropivacaine and 0.5% bupivacaine with adrenaline 1:200 000 at the end of operation respectively. RR: evaluation of effect of GNB, throat pain with 100 mm visual analog scale (VAS), the response for provoking gag reflex and swallowing ability were assessed in recovery room (RR), at 8 h and 24 h after surgery (8 h, 24 h).

**Results and Discussions:** The Table shows demographic and postoperative throat pain data (mean ± SD).

<table>
<thead>
<tr>
<th>Group</th>
<th>Age (y)</th>
<th>Sex (M/F)</th>
<th>Height (cm)</th>
<th>Weight (kg)</th>
<th>RR-RVAS</th>
<th>RR-SVAS</th>
<th>8h-RVAS</th>
<th>8h-SVAS</th>
<th>24h-RVAS</th>
<th>24h-SVAS</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>32 ± 9</td>
<td>10/5</td>
<td>168 ± 7</td>
<td>70 ± 18</td>
<td>41 ± 16</td>
<td>62 ± 16</td>
<td>27 ± 11</td>
<td>62 ± 17</td>
<td>18 ± 8</td>
<td>54 ± 20</td>
</tr>
<tr>
<td>R</td>
<td>36 ± 14</td>
<td>9/6</td>
<td>166 ± 11</td>
<td>69 ± 14</td>
<td>20 ± 16</td>
<td>27 ± 21</td>
<td>22 ± 18</td>
<td>53 ± 23</td>
<td>21 ± 21</td>
<td>52 ± 19</td>
</tr>
<tr>
<td>B</td>
<td>36 ± 9</td>
<td>10/5</td>
<td>167 ± 6</td>
<td>68 ± 13</td>
<td>20 ± 13</td>
<td>28 ± 18</td>
<td>21 ± 18</td>
<td>50 ± 15</td>
<td>19 ± 14</td>
<td>51 ± 17</td>
</tr>
</tbody>
</table>

GVAS: resting VAS scores, SVAS: swallowing VAS scores. *P < 0.05 vs. group C.

Gag reflex and swallowing ability were obtunded more severely both group R and group B than in group C (P < 0.01). RR-SVAS both group R and group B were strongly correlated with the extent of gag reflex and swallowing difficulty (p < 0.01). There was no significant difference in foreign body sense in posterior pharynx, postoperative nausea and vomiting and dyspnea within inter-groups.

**Conclusion(s):** GNB with local anesthetics can decrease immediate postoperative pain after tonsillectomy in adult patients.

### A-391

**Low-dose spinal ropivacaine for lower-limb surgery in an ambulatory setting**

M.J.S. Wenk, M. Sidowski, M. Mollmann

Department of Anaesthesiology and Intensive Care Medicine, St. Franziskus Hospital, Muenster, Germany

**Background and Goal of Study:** Ropivacaine, a relatively new amine-amide local anaesthetic, has recently been licensed for intrathecal application for various indications. There is however no official recommendation of any dosage regimen to be used in women undergoing caesarean section. We reviewed all caesarean sections done in our department using ropivacaine in different dosages.

**Materials and Methods:** 40 women undergoing elective caesarean section received the following doses of spinal ropivacaine: 10 mg + 0.1 mg morphine, 12.5 + 0.1 mg morphine, 12.5 mg or 15 mg of spinal ropivacaine. Patients did not receive any fluid preload. The level and duration of sensory block, intensity and duration of motor block using a modified Bromage score, time to mobilize and changes in mean arterial pressure were recorded at timed intervals.

**Results and Discussions:** 10 mg + 0.1 mg morphine was only used in two patients since it provided insufficient sensory and motor block. 15 mg of spinal ropivacaine produced sensory block at T3/4 level; 12.5 mg produced sufficient sensory block at T6/7 level but with a short duration of 72 ± 7 min until complete void of the block. 12.5 mg + 0.1 mg morphine provided sufficient sensory block at T6/7 level with a duration of 91 ± 17 min.

**Conclusion(s):** Low-dose ropivacaine is safe and easy to use in women undergoing caesarean section since it provides sufficient analgesia and motor block and haemodynamic depression is rare. Some dose-finding studies could not see any advantages of ropivacaine over other local anaesthetics but doses of ropivacaine used in those studies were much higher. Comparative studies between low-dose ropivacaine and other local anaesthetics used in women undergoing caesarean section are necessary.


### A-392

**The effectiveness of local intravesical anaesthesia with ropivacaine in minimal handling endoscopic procedures.**

G. Gorantonakis, V. Theodoropoulos, E. Lykoudi, A. Garnell, I. Gerzelis, L. Reffmos, K. Alexandrakis, A. Koutsis

Department of Anaesthesiology, Agia Olga General Hospital of N. Ionia, Athens, Greece

**Background and Goal of Study:** To assess the suitability, patients’ tolerance and side effects of intravesical use of ropivacaine in minimal endoscopic procedures.

**Materials and Methods:** The patient’s age was within 40 and 90 years and the procedures were performed in a single endoscopic theatre annexed to the urolgy ward. Group A – 16 patients underwent a follow up cystoscopy with taking biopsies after a transurethral resection (TUR-BT) of a superficial transitional cell tumor (TCC) and group B – 15 patients underwent electrocauterization of small papillary tumors (relapse of a low grade superficial tumor). 100 ml of solution with a concentration of 2 mg/ml ropivacaine HCL was intravesically administered 10 min prior to the procedure through a 12Fr Tiemann catheter. All patients were fully conscious and for the subjectively tolerance in handlings of a simple 4-grade pain scale was used during the procedure; (0 – absent discomfort, 1 – minimal discomfort, 2 = painful but tolerable sensation, 3 = intolerable pain). All patients were observed 3 hours postoperatively.

**Results and Discussion:** Most of the patients were able to walk back to their rooms or were discharged home on the day of operation. Side effects were minimal and not related to local anesthesia, such as mild hematuria. The procedure was well tolerated in all patients of group A, especially in the first 10 minutes. In 3 patients of group B a light sedation was necessary because of a little prolongation of the procedure. In one patient, because of a moderate hematuria and the analogous prolongation of the procedure, a spinal block was intentional.

**Conclusions:** Local intravesical anesthesia with ropivacaine proved to be effective for short time minimal endoscopic procedures, with the respective reductions in cost and the avoiding of general or spinal anesthesia. Patients could be treated in an out-patient basis with minimal complications and good level of patient acceptance.
A-393

Inferonasal vs inferotemporal approach for sub-Tenon’s block
H. McLure, S. Bata, C. Kumar, R. Chabria, S. Ahmed, S. Williamson
Department of Anaesthesia, St James’s University Hospital, Leeds, United Kingdom

Background and Goal of Study: An inferonasal (IN) sub-Tenon’s block may be performed for ophthalmic surgery. In circumstances where the IN approach is contra-indicated, the infero-temporal (IT) can be used. There are no data on the relative efficacy of the IN compared with the IT route.

Materials and Methods: 100 patients undergoing cataract extraction were randomised to receive an IN or IT sub-Tenon’s injection of 3–4 ml of lidocaine 2%. Akinia was assessed using the Brahma scale at 0, 2, 4, 6 & 8 minutes by a blinded observer. Injection, pre-op and postoperative pain scores (VAS 0–10) were noted, along with the incidence of conjunctival haemorrhage (SCH) and chemosis.

Results and Discussions: There were no differences in demographic data, or mean volume of administered local anaesthetic solution (3.3 (SD 0.4) mls). The Table shows mean (SD) akinesia, pain scores and number of patients with minor complications in each group.

<table>
<thead>
<tr>
<th>IN (n = 48)</th>
<th>IT (n = 52)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 min akinesia</td>
<td>2.7 (2.18)</td>
<td>2.2 (2.23)</td>
</tr>
<tr>
<td>4 min akinesia</td>
<td>1.1 (1.66)</td>
<td>0.9 (1.52)</td>
</tr>
<tr>
<td>6 min akinesia</td>
<td>0.4 (1.35)</td>
<td>0.8 (1.68)</td>
</tr>
<tr>
<td>8 min akinesia</td>
<td>0.2 (1.03)</td>
<td>0.3 (1.19)</td>
</tr>
<tr>
<td>Injection pain</td>
<td>0.9 (1.39)</td>
<td>1.1 (1.48)</td>
</tr>
<tr>
<td>Pre-op pain</td>
<td>0 (0.2)</td>
<td>0 (0.50)</td>
</tr>
<tr>
<td>Postop pain</td>
<td>0 (0)</td>
<td>0 (0.65)</td>
</tr>
<tr>
<td>Chemosis</td>
<td>14</td>
<td>22</td>
</tr>
<tr>
<td>SCH</td>
<td>14</td>
<td>19</td>
</tr>
</tbody>
</table>

Conclusions: The IT provides an equally rapid and dense block to the IN approach, without a significant increase in minor complications.

Reference:

A-394

A comparison of three intravenous sedation techniques in phacoemulsification under topical anaesthesia
S.J. Hashemi, H.A. Soltani, K. Kianafraz
Department of Anaesthesiology and Critical Care, Isfahan University of Medical Science, Isfahan, Iran

Background and Goals: There has been a significant shift toward the use of topical anaesthesia with ligh sedation for routine cataract surgery (1,2). This study evaluated the sedation status following use of three intravenous sedation techniques for cataract surgery under topical anaesthesia.

Material and Methods: After ethics committee approval and informed consent, this controlled clinical trial study was performed on 150 patients who were candidates for phacoemulsification surgery. Patients randomly divided equally in three groups. Following oral explanation of procedure to patients, and administration of topical anaesthesia with tetracaine 0.5%, group 1 received fentanyl 1–1.5 μg/kg and ketamine 0.2 mg/kg intravenously. In addition to these drugs, propofol 10–20 μg/kg/min and lidocaine 0.7 mg/kg i.v. were administered in groups 2 and 3 respectively. Blood pressure, heart rate, sedation; cooperation and pain score, patient and surgeon satisfaction, PONV and delirium were assessed. Statistical analysis was performed by χ² and ANOVA.

Results: Data are shown in the Table.

<table>
<thead>
<tr>
<th>Group</th>
<th>Cooperation (Mean ± SD)</th>
<th>Frequency of appropriate cooperation (N, %)</th>
<th>Frequency of appropriate sedation (N, %)</th>
<th>Patient satisfaction (Mean ± SD)</th>
<th>Surgeon satisfaction (Mean ± SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group1</td>
<td>4.00 ± 1.01</td>
<td>35 (70)</td>
<td>40 (80)</td>
<td>3.64 ± 0.89</td>
<td>2.94 ± 1.09</td>
</tr>
<tr>
<td>Group2</td>
<td>4.12 ± 1.06</td>
<td>38 (76)</td>
<td>43 (86)</td>
<td>3.74 ± 0.52</td>
<td>3.10 ± 1.03</td>
</tr>
<tr>
<td>Group3</td>
<td>4.06 ± 0.92</td>
<td>38 (76)</td>
<td>39 (78)</td>
<td>3.62 ± 0.69</td>
<td>3.02 ± 1.05</td>
</tr>
</tbody>
</table>

Conclusions: In previous studies, the preference of some sedation methods to other protocols was proved but in present study this subject was not significant. This issue may be due to patient selection, preoperative psychological preparation; optimum drugs dose selection, compatible drugs combination and surgeon skill. Effect of these parameters on sedation quality needs more evaluation.

References:

A-395

The efficiency of the administration site, volume and concentration of infiltrative bupivacaine, on postoperative analgesia
Department of Anaesthesiology and Reanimation, Mersin University, School of Medicine, Mersin, Turkey

Background and Goal of Study: It is generally agreed that the tissue plane may modulate the efficiency of infiltrative block. We aimed to investigate the importance of the volume and the concentration of bupivacaine in the analgesic efficacy in addition to tissue plane in this study.

Materials and Methods: 80 patients with ASA II–III who underwent suprapubic transvesical prostatectomy were included in the study after approval of ethical committee. The patients were randomly assigned to four groups of equal numbers and the technique of general anaesthesia was standardized across the groups. Before closure of the skin, the wound site was infiltrated either with 0.25% bupivacaine 40 cc suprafascially (Group SF-1, n = 20) or with 0.5% bupivacaine 20 cc suprafascially (Group IF-2, n = 20). The remaining 40 patients were infiltrated either with 0.25% Bupivakaine 40 cc infrafascially (Group IF-1, n = 20) or with 0.5% bupivacaine 20 cc infrafascially (Group IF-2, n = 20). The patients were evaluated postoperatively with VAS, and I.M. meperidine 1 mg kg⁻¹ was administered to patients with VAS score over 4. The postoperative SpO₂ values, hemodynamic status, VAS scores and the need of additional analgesics of the patients were recorded. Mann-Whitney U and Friedman tests were used for statistical analysis and P values under 0.05 were considered as statistically significant.

Results and Discussions: Within the group comparisons showed that VAS scores were significantly higher in group SF-2 than SF-1 (P = 0.021), and significantly higher in group IF-2 than IF-1 (P = 0.009). When all groups were compared, the VAS scores were as follows: Group SF-2 > Group IF-2 > Group SF-1 > Group IF-1 (P < 0.001). When all the groups were compared according to the need of additional analgesics, the need of additional analgesics in group SF-2 was the highest among the groups (90% in group IF-1, 70% in group IF-2, 55% in group SF-1 and 30% in group SF-2, P = 0.01).

Conclusion(s): In infiltrative bupivacaine applications, the tissue plane and the volume of bupivacaine was important in determining the analgesic efficiency, rather than the concentration of bupivacaine. The reason may be the removal of more pain mediators from the environment with higher volumes of bupivacaine.

A-396

Complications of intercostal catheter analgesia vs. intercostal nerve blockade for postthoracotomy pain relief
S. Kvolik, J. Kristek, K. Sakic, O.K. Tot
Department of Anaesthesiology and Intensive Care Unit, Clinical Hospital Osijek, Osijek, Croatia

Background: Postthoracotomy pain relief can be achieved by several analgesic regimens. An aim of this prospective randomised study was to compare analgesic effects and postoperative/postanaesthetic complications of two regional anaesthetic techniques.

Materials: After informed consent was obtained 80 patients 40–70 years were scheduled for elective operations were divided in two groups: A (n = 40) intercostal (IC) analgesia, and B (n = 40) IC catheter analgesia. All patients were given perioperative antibiotic prophylaxis (Cefazolin 1 g) and dose adjusted thromboprophylaxis.

Methods: The intercostal nerve blockade was performed using 5 ml of 0.5% bupivacaine for blockade of intercostal nerve in thoracotomy wound, nerve below and above thoracotomy. IC catheter analgesia was achieved through catheter placed at the end of an operation into intercostal space by surgeon. 20 ml of 0.5% bupivacaine was injected Additional increments of local anaesthetics were repeated every 12 hours. Chest drainage was removed at day 1st to 3rd and chest X-rays were done at 3rd day.

Visual analogue pain score (VAS) was obtained preoperatively, 24, 48 and 72 hours after operation. Differences between groups were calculated using t-test (p < 0.05).
Results: VAS scores ± SD are shown in Table 1.

<table>
<thead>
<tr>
<th></th>
<th>Preop.</th>
<th>IC catheter</th>
<th>IC nerve block</th>
</tr>
</thead>
<tbody>
<tr>
<td>VAS</td>
<td>1 PO</td>
<td>2 PO</td>
<td>3 PO</td>
</tr>
<tr>
<td>IC catheter</td>
<td>0</td>
<td>2.2 ± 0.52</td>
<td>1.9 ± 0.7</td>
</tr>
<tr>
<td>IC nerve block</td>
<td>0</td>
<td>3.0 ± 0.81</td>
<td>3.6 ± 0.84*</td>
</tr>
</tbody>
</table>

*A statistically significant difference.

Table 2. Postoperative complications recorded at discharge.

<table>
<thead>
<tr>
<th>Complication</th>
<th>IC block</th>
<th>IC catheter</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infiltrated hematoma of the wound</td>
<td>2</td>
<td>3</td>
<td>0.93</td>
</tr>
<tr>
<td>Pneumothorax</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Pleural infections</td>
<td>2</td>
<td>1</td>
<td>0.29</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>4</td>
<td>3</td>
<td>0.36</td>
</tr>
<tr>
<td>Atelectasis</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

Conclusions: According to the VAS the pain control was thoroughly con-
trolled by intercostal catheter analgesia. However, statistically significant differ-
ences between postoperative complications were observed in two groups.

Reference:

A-398

Efficacy of low-volume episcleral single injection anesthesia in anterior chamber surgery
J. Serra, R. Asbert, F. Fontao, J. Bernal, C. Pérez, A. Salvador
Department of Anesthesia and Reanimation, Hospital Mutua de Terrassa, Terrassa, Spain

Background and Goal of Study: The purpose of this study was to evaluate the efficacy of low-dose episcleral single injection anesthesia in anterior chamber surgery.

Materials and Methods: We included prospectively 232 patients scheduled for anterior chamber surgery over a period of 6 months (March–August). All patients received a medial canthus episcleral single injection of less than 5 ml of local anesthetics. The success rate of the block was measured according to akinesia, pain, and surgeons and patients satisfaction scales. All patients were followed until postoperative day 8 and complications were recorded.

Results and Discussions: A total of 232 patients were included. All blocks were performed by experienced anesthesiologists, skilled in ophthalmic anesthesia. The most frequent surgical procedure was phacoemulsification and intraocular lens implantation. No major complication (retinal hemorrhage, optic nerve lesion or eye perforation) was observed. The most frequent minor incidence were subconjunctival hemorrhage (7,3%), caruncular hematoma (3%) and transient ocular hypotonia (2%). No single procedure was cancelled or delayed due to any complication. No different anesthetic technique was required to perform any procedure.

Conclusion(s): Single episcleral injection with low volume of local anesthetics is a safe, simple, time sparing and efficacious method. Requires a relative short training period and represents an alternative to classical techniques in anterior chamber surgery.

References:

A-400

Does catheter tip stiffness affect the incidence of complications during the lower thoracic epidural catheterization?
Department of Anesthesiology, Chiba-Hokusoh Hospital, Nippon Medical School, Chiba, Japan

Background and Goal of Study: We reported that the incidence of pares-
thesia associated with epidural catheterization was not affected by the catheter stiffness. However, we hypothesized that the stiffness of catheter tip might affect the incidence of complications during the procedure. We compared the incidence of complications between polyamide catheter (PLA) and polyamide soft tip catheter (PLA Soft Tip) during epidural catheter placement in the lower thoracic region.

Materials and Methods: After obtaining IRB approval and informed con-
sent, adult patients were randomly divided into two groups according to the type of catheter used: i.e. Group A: 20G, PLA (n = 168) and Group B: 20G, PLA Soft Tip (n = 167). The patient was positioned in a moderate chest-knee position. Epidural puncture was performed via paramedian approach at T11–12 interspace. The epidural space was identified by the loss-of-
resistance technique to saline. The catheter was inserted 5 cm in the epidural space. Occurrence of complications was recorded. Data were ana-
lyzed with unpaired t-test or Chi-square analysis with Yates correction as appropriate. P < 0.05 was considered significant.

Results and Discussions: Patients characteristics and number of attempts at needle insertion (Group A: 1.2 (0.5) and Group B: 1.2 (0.5) mean (SD) (P = 0.8949)) were comparable between the groups. No signs suggesting major complications were recognized in all patients. Insufficient block was not recorded in each patient. Statistically significant differences were demonstrated between the groups for the following factors: (1) transient paresthesia (7.7% vs. 1.2%, P = 0.0085); (2) resistance to introduction of the catheter (8.9% vs. 0.6%, P = 0.0009). Occurrence ratio of blood aspiration was comparable among the groups (1.8% vs. 2.4%, P = 0.9827). In the lower thoracic region, the location of the epidural sac forms an oval or a hex-
gon. This might influence the position of the catheter and the incidence of resistance during the catheter placement.

Conclusions: We conclude that the reduced incidence of paresthesia and resistance to placement of the catheter observed in our study with the PLA Soft Tip is presumably because of the straight and or midline course taken by the catheter.

A-401

A new method to confirm epidural puncture
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Background and Goal of Study: The loss-of-resistance method sometimes results in difficulty identifying the epidural space, particularly in obese or elderly patients. We developed a new method to confirm epidural punc-
ture by changing epidural pressure (EP) using the Quenkeenstedt-Stocks test procedure (QST), which increases subarachnoid pressure by pressing the internal jugular vein. The present study evaluated the reliability of this new method.

Materials and Methods: The new method was examined in 30 patients who underwent cervical decompression surgery for cervical myelopathy or ossification of the posterior longitudinal ligament. All patients displayed spinal canal stenosis and received EP monitoring with the QST through a Touhy needle for electrode catheterization at T10–L2 for orthopedic diagno-
sis. Epidural catheterization was confirmed by electric stimulation (5 mA, 2 Hz) and postoperative radiography. In addition, 50 patients who underwent celiotomy or thoracotomy also received EP monitoring with the QST to confirm epidural puncture for catheterization at T5–L5. Changes in EP were recorded during the QST, and epidural catheterization was confirmed by perioperative analgesic effects and postoperative radiography.

Results and Discussions: Increased EP during the QST was clearly observed in 30 orthopedic patients (mean JEP: 5 ± 3 mmHg; range 2–10 mmHg), and the electrode in the epidural space was detected by electrical stimulation and radiography. In the 50 cases of celiotomy or thoracotomy, increased EP and epidural catheterization were observed in 49 patients (mean JEP: 4 ± 2 mmHg; range 2–11 mmHg), although no change in EP was observed in 1 case with the catheter tip in the thoracic cavity.

Conclusion(s): EP monitoring combined with the QST could offer a good method for confirming epidural puncture when results from the loss-of-
resistance method are unclear.

A-402

Epidural ropivacaine with sufentanil in lower abdominal surgery: a randomized double-blind study
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Background and Goal of Study: Ropivacaine is a long acting amide local anesthetic agent, administered epidurally to patients undergoing various surgical procedures. The aim of this study was to assess the efficacy and clinical outcome of epidural ropivacaine combined with sufentanil in a random-
ized, double-blind, controlled trial.

Materials and Methods: After approval of the local ethics committee and informed consent, forty male patients (ASA I-II, aged between 30-65) undergoing inguinal hernia repairment under epidural anesthesia were assigned into two groups receiving 0.75%, 15 mL ropivacaine (Group I) or 0.75%, 15 mL ropivacaine combined with 10 mcg sufentanil (Group II). The spread and dura-
tion of sensory anesthesia was assessed by pinprick, and that motor block was assessed using a Modified Bromage Scale. A blinded observer evaluated onset time and regression of motor and sensory block, quality of analgesia, hemodynamic parameters, time to first analgesic requirements and all side
Effects. Pain was measured on a visual analog scale (VAS: 0: no pain; 10 cm: unbearable pain). SPSS for Windows 10.0 were used in statistical analysis and p values <0.05 was considered statistically significant.

Results: There were no differences in respect of patient characteristics, initial onset and degree of motor block, quality of analgesia, peak sensory block level and all side effects. VAS scores and haemodynamic parameters were similar. The onset time of sensory block was 4.93 ± 0.69 min and 3.72 ± 1.37 min in Group I and II respectively (p < 0.001). The time to first analgesic requirement was longer, although the two-segment regression time was shorter in Group II (p < 0.001).

Conclusion(s): Epidural anesthesia with ropivacaine plus sufentanil provided efficient pain relief, haemodynamic stability and minor side effects. A clinical concern regarding patient satisfaction, the rapid regression of sensory and motor block and longer duration of analgesia might be advantageous.

Reference:

A-403
Low back pain after epidural anesthesia: two different approaches
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Background and Goal: Low back pain (LBP) is a common minor yet unpleasant complication after epidural anesthesia. Different mechanisms are suggested such as needle trauma and myotoxicity of local anesthetic.

Material and Methods: 273 ambulatory patients ASA I-III, aged 20–73 years old undergoing lumbar epidural anesthesia (levobupivacaine 0.5%) were assigned randomly to one of the two groups of the study. Group M (n = 142) in which epidural puncture was performed by median approach and group P (n = 131) in which epidural puncture was performed by paramedian approach (lateral position, L4/5 or L3/4 interspace). In both groups needle Tuohy 18 G was used. All patients were mobilised 6–7 hrs after operation. We recorded the number of epidural puncture attempts and the occurrence and duration of backache in the patients. All patients were followed up for 20 days. In the case of backache mild analgesics and NSAIDs were prescribed together with rest. Statistical analysis was achieved by using chi-square test and ANOVA-one way.

Results and Discussion: Results and Discussions: Both groups were comparable. The results are shown in the next table:

<table>
<thead>
<tr>
<th></th>
<th>Group M</th>
<th>Group P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients with LBP (%)</td>
<td>6 (4.5%)</td>
<td>2 (1.5%)</td>
</tr>
<tr>
<td>Number of epidural attempts in patients with LBP</td>
<td>1.7 ± 0.8</td>
<td>1.4 ± 0.7</td>
</tr>
<tr>
<td>Number of epidural attempts in all patients</td>
<td>1.7 ± 0.7</td>
<td>1.4 ± 0.6</td>
</tr>
<tr>
<td>Duration of LBP (days)</td>
<td>8 ± 2</td>
<td>5 ± 2*</td>
</tr>
</tbody>
</table>

* p < 0.05

Conclusions: Taking into consideration the above results the paramedian approach of the epidural space seems to be associated with a lower incidence of low back pain.

A-404
The effect of epidural anaesthesia on the course of isolated continuous hyperthermic perfusion chemotherapy (CHPCH)
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Background and Goal of Study: Concomitant application of chemotherapy and hyperthermia significantly improves the results of cancer treatment. Real hyperthermia above 40 degree C is most effective. Extracorporeal circulation is used for heating and perfusion of the extremity with the chemotherapeutic agents.

Materials and Methods: 21 patients, aged from 26 to 72 years, ASA II, were treated with CHPCH for recurrent melanoma. The patients were divided into two groups. Group A consisted of 10 patients treated under general anesthesia and group B included 11 patients operated under general anesthesia combined with continuous epidural analgesia.

The time of heating of the extremity and the highest temperature achieved during the procedure were assessed. The results were verified statistically with the Student’s t-test, with the significance level at p < 0.05.

Results and Discussions: In group A, mean time of heating was 92,7 min ± 41,3 min and the mean temperature achieved was 39,7 degree C ± 1,07. In group B, heating lasted 59 min ± 27 min on the average, and the mean temperature of achieved was 40,5 degree C ± 0,97.

Conclusion(s):
1. The time of heating of the extremity and the extracorporeal perfusion phase were shorter in the patients under combined epidural and general anesthesia.
2. In both groups mean temperature was almost the same.
3. Despite full dose of heparin was administered no local complications were noted.

References:
1 J. van der Zee, et al., Eur J Cancer, 1997, 10, 1546-50

A-405
Effect of thoracic epidural anaesthesia on desflurane and sevoflurane requirement during major abdominal surgery
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Background and Goal of Study: The combination of epidural and general anaesthesia during major abdominal surgery decreases the dose requirement of volatile anaesthetics. However, “light” anaesthesia may result in inadequate depth of hypnosis and intraoperative awareness. The aim of the present study was to determine the endtidal concentration of desflurane and sevoflurane during combined anaesthesia under neuromonitoring by BIS® and Narcotrend™.

Materials and Methods: After institutional approval and written informed consent, forty patients (ASA II–III), undergoing major abdominal surgery under combination of general and epidural anaesthesia, were randomly assigned to two groups, receiving either desflurane or sevoflurane for maintenance of general anaesthesia. Intraoperative analgesia was provided by epidural application of 10 ml ropivacaine 0.3% and 10 μg sufentanil every 60 min. Following incision, enthalial concentration was then reduced stepwise under monitoring of anaesthetic depth to a maximum Narcotrend stage of D1 (55) or BIS level of 55. Increases in the mean arterial pressure for more than 20% to baseline values were treated by increasing the volatile anaesthetic to 1 MAC and additional rescue analgesia with remifentanil infusion, respectively. Patients were interviewed following surgery and two days later for intraoperative awareness and recall.

Results and Discussions: Results and Discussions: Performance of combined anaesthesia was possible in all patients. There were no differences were in patients’ characteristics, type and duration of surgery. Endthalial concentration of desflurane and sevoflurane could be reduced from 1 MAC (2.9 ± 0.1 to 0.9 ± 0.2 and 1.0 ± 0.05 to 0.4 ± 0.1 Vol%) to 0.5 MAC and 0.4 MAC respectively. Intraoperative epidural analgesia was sufficient and rescue analgesia with remifentanil was not applied. None of the patients reported intraoperative awareness or recall. Extubation times were 90 ± 12 and 87 ± 9 sec respectively following discontinuation of volatile anaesthetics.

Conclusion: Monitoring of anaesthetic depth during combined anaesthesia allows an individual adjustment of the enthalial concentration of desflurane and sevoflurane, providing stable haemodynamics, short recovery with no signs of intraoperative awareness or recall.

A-406
The benefits of intra- and postoperative use of epidural analgesia in patients undergoing liver surgery
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Background and Goal of Study: Prolonged gastrointestinal dysfunction is a common early complication in patients receiving major abdominal surgery, resulting in delayed rehabilitation and prolonged hospital stay. Multimodal collaborative clinical pathways can implement sympathicolytic methods for pain relief like epidural analgesia, providing much more than pure analgesia as...
opposed to intravenous opioid analgesia. However, concerns have been voiced in regards to epidural analgesia during types of surgery with an increased risk of intraoperative bleeding. The purpose of the present study was to evaluate the effects of intra and postoperative epidural analgesia on blood loss, transfusion requirement and postoperative restoration of gastrointestinal function.

**Materials and Methods:** The records of 269 patients receiving liver resection between 1994 and 2003 were analysed regarding the intra and postoperative use of epidural analgesia. Blood loss, transfusion requirements as well as gastrointestinal dysfunction and time to first oral intake were recorded. Absence of bowel sounds and defaecation for more than 4 postoperative days were regarded as gastrointestinal dysfunction.

**Results and Discussions:** Complete records could be analysed in 238 patients. 27 patients were treated by thoracic epidural analgesia (group TEA) and 111 patients received patient controlled intravenous analgesia with piritramide (group PCIA) due to contraindications against central neuraxial blocks or refusal. Groups did not differ regarding patient characteristics, type and duration of surgery as well as intraoperative blood loss and transfusion requirements. Duration of gastrointestinal dysfunction was significantly reduced in group TEA (2.7 ± 1.6d vs 4.1 ± 1.6d; p < 0.0005), as was first oral intake of solid food (3.4 ± 1.1d vs 4.3 ± 1.6d; p < 0.01). Need for ICU admission and mechanical ventilation was likewise reduced in TEA.

**Conclusion(s):** There was no evidence of increased blood loss or need for transfusion by the intraoperative use of TEA. TEA rather than PCIA offered reduced in group TEA (2.7 ± 1.6d vs 4.1 ± 1.6d; p < 0.0005), as was first oral intake of solid food (3.4 ± 1.1d vs 4.3 ± 1.6d; p < 0.01). Need for ICU admission and mechanical ventilation was likewise reduced in TEA.

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**A-407**

**Effect of epidural ropivacaine concentration on desflurane requirement during major abdominal surgery under monitoring the anaesthetic depth – a randomized, controlled, double blind investigation**

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**Background and Goal of Study:** The intraoperative use of epidural analgesia in combination with general anaesthesia provides stable intraoperative haemodynamics and reduces requirement of volatile anaesthetics. The aim of the present study was to investigate the effects of different doses of epidural applied ropivacaine on dose requirement of desflurane during combined anaesthesia under monitoring of anaesthetic depth by BIS® and Narcotrend®.

**Materials and Methods:** After institutional approval and written informed consent, 60 patients (ASA II-III), undergoing major abdominal surgery under combined anaesthesia, were randomly assigned to 3 groups receiving 10 ml ropivacaine 0.5% and 5 µg sufentanil, 10 ml ropivacaine 0.2% and 5 µg sufentanil and placebo 10 ml NaCl 0.9% (groups 1–3, respectively) every 60 minutes for intraoperative anaesthesia. Following incision, etidocaine concentration of desflurane was then reduced under monitoring of anaesthetic depth to a maximum Narcotrend stage D1 (55) or BIS level of 55 increases in mean arterial pressure for more than 20% to baseline values were treated by increasing desflurane concentration to 1 MAC and additional rescue analgesia with remifentanil.

**Results and Discussion:** Endtocal concentration of desflurane could be significantly reduced from 2.8 ± 0.2 Vol% to 1.2 ± 0.3 Vol% (0.5 MAC) and to 1.5 ± 0.5 Vol% (0.6 MAC) in groups 1 and 2, respectively (p < 0.005). In group 3, reduction of desflurane requirement could not be achieved; additional remifentanil infusion was required for rescue analgesia (1.4 ± 0.7 mg remifentanil/h). Patients in group 1 received significantly more norepinephrine (60 ± 38 µg/h) for patients in group 2 (40 ± 19 µg/h) and group 3 (28 ± 19 µg/h) for restoring mean arterial pressure (p < 0.005).

**Conclusion:** Epidural application of ropivacaine during combined anaesthesia reduces dose dependency of desflurane. Under comparable anaesthetic depth, a concentration of 0.2% of ropivacaine provided adequate intraoperative analgesia resulting in less haemodynamic side effects compared to a 0.5% concentration.

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**A-408**

**The effects of combined epidural anaesthesia on recovery in kidney donation patients**

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**Background and Goal of Study:** In this preliminary study we evaluated the hypothesis that combined epidural with general anaesthesia insures convenient and shorter postoperative recovery compared with general anaesthesia alone in patients undergoing traditional open donor nephrectomy.

**Materials and Methods:** 17 patients, who were randomised to either just general anaesthesia (group A, 7 patients) or a combined general with epidural anaesthesia (group B, 10 patients). Analgesia in group A was maintained with sufentanil, and in group B with bupivacain 0.25% with 2 µg sufentanil/cc. After the operation group B received morphine epidural, group A received morphine i.v. After that all patients were given a PCA pump with morphine.

Those patients were interviewed preoperatively, and 15 and 40 minutes after detubation. A Mini Mental State Examination (MMS) and VAS-scores concerning pain, fatigue, nausea and comfort were used.

**Results and Discussions:** Data are shown in the tables:

<table>
<thead>
<tr>
<th></th>
<th>Pain</th>
<th>Fatigue</th>
<th>Nausea</th>
<th>Discomfort</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group A</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean VAS-scores</td>
<td>6.3</td>
<td>4.7</td>
<td>1.4</td>
<td>5.6</td>
</tr>
<tr>
<td></td>
<td>(2.7)</td>
<td>(3.4)</td>
<td>(2.1)</td>
<td>(2.9)</td>
</tr>
<tr>
<td><strong>Group B</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean VAS-scores</td>
<td>1.8</td>
<td>2.9</td>
<td>1.1</td>
<td>2.6</td>
</tr>
<tr>
<td></td>
<td>(2.9)</td>
<td>(3.3)</td>
<td>(2.7)</td>
<td>(2.9)</td>
</tr>
</tbody>
</table>

Mean VAS-scores (=s.dv) 40 min. after detubation

**Conclusion(s):** These preliminary data suggests that the chosen anaesthesia technique (general combined with epidural anaesthesia) has no significant effect on the postoperative mental score. However VAS-scores for pain, fatigue and discomfort, and moment of detubation, show a preference for the combination technique.

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**A-409**

**The effect of postoperative epidural analgesia vs NCA morphine on pain and rehabilitation after surgery for hip fracture: A randomized, doubleblinded, placebo-controlled study**

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**Background and Goal of Study:** Hip fracture surgery is characterized by a high demand for rehabilitation and a significant risk of perioperative morbidity and mortality (1). Postoperative epidural analgesia may reduce postoperative morbidity, and has been shown to facilitate rehabilitation in elective orthopedic procedures. No studies exist on the effect of postoperative epidural analgesia on pain and rehabilitation after hip fracture surgery.

**Materials and Methods:** Sixty patients were included in a randomized, double-blind study comparing 4 days of continuous postoperative epidural infusion of 4 ml h⁻¹ of bupivacaine 0,125% and morphine 50 mcg ml⁻¹ versus placebo (saline). Both patient groups received balanced analgesia and intravenous nurse-controlled analgesia with morphine. All patients followed a well-defined multimodal rehabilitation program (2). Assessment of pain and the ability to participate in four basic physical exercise functions, were done on each of the first four postoperative days.

**Results and Discussions:** Epidural analgesia provided superior dynamic analgesia during all basic physical functions on the 1st and 2nd postoperative day, and patients were significantly less restricted by pain on these days, where pain was the dominating restricting factor in the placebo group. Motor blockade was not a restricting factor during epidural analgesia. Despite improved pain relief, scores for recovery of physical independence were not different between groups on any days. Further optimization of perioperative care could potentially translate this superior analgesia into increased rehabilitation.

**Conclusions:** Postoperative epidural analgesia after hip fracture surgery provides superior analgesia and attenuates pain as a restricting factor during rehabilitation without clinically relevant motor dysfunction.

**References:**
A-410
Comparison of epidural ropivacaine, epidural bupivacaine and conventional opioid analgesia for pectus excavatum repair

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Background and Goal of Study: Thoracic epidural analgesia (TEA) is increasingly used for pectus excavatum repair (PER) [1, 2]. The aim of this study was to compare continuous thoracic epidural infusion of ropivacaine (R), bupivacaine (B) and conventional opioid analgesia (O) for perioperative analgesia in children undergoing PER.

Materials and Methods: 60 children (11–18 years) were randomized to receive either 0.5% R with 7.5 μg/ml fentanyl (n = 20) or 0.375% B with 7.5 μg/ml fentanyl (n = 20) by epidural infusion. Children were recruited to O (n = 20) when the epidural catheter was not inserted due to the lack of patient’s consent or technical difficulties. Standard general anesthesia, supplemented by epidural infusion was performed. In the postoperative period epidural infusion of 0.1% Ropivacaine or 6 μg/ml fentanyl, 0.075% Bupivacaine with 6 μg/ml fentanyl or repeated s.c. injections of morphine (0.1 mg/kg every 5 hours) were administered. Standard haemodynamic parameters and the level of pain (Prince Henry Hospital Pain Score – PHHPS, Numerical Rating Scale – NRS) were recorded. Sedation score (Ramsay Score – RS) and side-effects were also noted. Data were compared with the use of ANOVA and Kruskal-Wallis test. p < 0.05 was considered significant.

Results and Discussions: Exutution time was shorter in both epidural analgesia groups, when compared to O group (p ≤ 5 for R, 10 ≤ 4 for B and 30 ≤ 15 for O, p < 0.01). Haemodynamic stability was comparable in R and B group with the mean heart rate being significantly lower in both in epidural groups compared to O group. Level of pain and the requirement of “rescue” analgesia was higher in O group and comparable in both epidural groups.

Conclusions: TEA combined with general anaesthesia is superior to general anaesthesia alone for PER in children. Epidural analgesia with R is comparable to B in this group of patients.

References:

A-411
Pain management in uterine fibroid embolization

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Background and Goals: The embolization of intramural uterine myomas is an alternative to hysterectomy. It is an interventional radiological technique, through the femoral artery, in which one or several myomas are located and embolized with acrylic microspheres. Acute ischemia provokes intense pain that needs to be properly relieved during the first 24 hours at hospital and later at home, so we need to seek to best form of pain relief for our patients (1).

Material and Methods: Prospective observational study, women scheduled for uterine fibroid embolization are involved. Lumbal Epidural catheter is placed, and a first dose of 10 ml Bupivacaine 0.25% with epinephrine is administered before the procedure begins. During the technique we provide a conscious sedation to the patients with midazolam (1–3 mg) or remifentanil perfusion 0.025–0.05 μg/kg/min. Once the technique ends, an epidural catheter in modality of patient controlled analgesia (PCA) is started with bupivacaine 0.1% with epinephrine + 2 μg fentanyl/ml, 5 ml bolus, 20 minutes lockout and no background infusion. This analgesic guideline is maintained for 18–24 hours. Once discharged, an oral analgesia is provided during one week.

Results: 25 patients were included: unique myoma (17) and polimyomatosis uterus (8). The size of myomas was between 49–109 mm. 9 patients required the administration of epidural bolus during the procedure. The average of hospitalization was 34,78 hours (24–96). 19 patients obtained a controlled pain, visual analogue scale (VAS) 4–5 and 8 cases presented VAS > 5. We have observed that the pain relief of myoma and the pain score.

Conclusions: Myoma embolization technique produces a painful acute ischemia. Epidural infusion via PCA with bupivacaine and fentanyl seems to provide a good pain relief.

References:

A-412
72 h epidural infusion of 0.125% levobupivacaine reduces patient-controlled morphine consumption and improves pain relief after major knee surgery

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Background and Goal of Study: This prospective, randomised, open-label, multicenter investigation tested the hypothesis that epidural infusion of 0.125% levobupivacaine from 24 to 72h after major knee surgery still reduces morphine consumption.

Materials and Methods: The study was conducted in 13 hospitals in Italy, Hungary and Spain. With ethic committee approval and written informed consent 186 patients, who had received epidural analgesia with 0.125% levobupivacaine for first 24 hours after knee replacement surgery were randomly allocated to receive either epidural infusion of 0.125% levobupivacaine with IV PCA morphine for rescue analgesia (group Levo, n = 90) or IV PCA morphine alone (group Control, n = 96) for the following 48 hours (up to 72 hours). Patients were observed at 6 hour intervals. The degree of pain (100 mm VAS), time to first PCA request, hourly morphine consumption, and safety parameters were recorded.

Results and Discussions: No differences in anthropometric variables were observed between the two groups. The degree of pain was less from 6 to 48h after randomisation in group Levo than in group Control (P < 0.05). Mean (SD) morphine consumption per hour was 0.52 ± 0.9 mg in the Levo group and 0.83 ± 0.9 mg in the Control group (P = 0.006), while first PCA morphine request occurred after 2.9 ± 6 (range: 0.0–36) h in the Levo group and 3.8 ± 9 (range: 0.0–37.7) h in the Control group (P = 0.0001). In the Levo group a Bromage’s score >1 was reported in 3 cases (3.3%) at the 48h and 1 case (1.1%) at the 72h, while no patients in the Control group showed a Bromage score >1 (P = 0.11 and P = 0.48, respectively). No severe adverse events related to study drug were reported in either group.

Conclusions: Prolonging epidural infusion of 0.125% levobupivacaine for up to 72h after major knee surgery reduces hourly PCA morphine consumption and improves the quality of pain relief without affecting recovery of motor function as compared to intravenous PCA morphine.

A-413
Thoracic epidural analgesia reduces incidence and duration of prolonged mechanical ventilation in patients undergoing transsternal thymectomy for myasthenia gravis

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Background and Goal of the Study: Patients suffering from myasthenia gravis (MG) have an increased risk for prolonged mechanical ventilation and pulmonary complications following transsternal thymectomy. In 1998 thoracic epidural analgesia (TEA) was implemented as a method of intra and postoperative analgesia within a clinical pathway in such patients in our institution. The purpose of the present study was to examine the incidence and duration of ventilatory support as well as pulmonary complications in myasthenia patients undergoing thymectomy.

Material and Methods: After institutional approval the records of 40 consecutive MG-patients undergoing transsternal thymectomy between 1/1998 and 9/2004 were examined. All patients received general anaesthesia (GA) with desflurane up to 1 MAC in 50% O₂ for maintenance, propofol or thiopentone for induction, and reduced doses of muscle relaxants to facilitate tracheal intubation. All patients were offered thoracic epidural analgesia for intra and postoperative analgesia, however, only 20 patients received TEA (group TEA) due to contraindications or refusal. Patients without TEA (group GA; n = 20) received fentanyl to maintain MAC values for desflurane below 1 MAC (age-adjusted) and paracetamol for postoperative analgesia (group GA).

Results and Discussions: Groups did not differ regarding patients characteristics, stage of MG (Ossermann’s score) and daily doses of cholinesterase inhibitors. No patient required prolonged mechanical ventilation in group TEA, however, 38% of patients could not be extubated immediately in group GA (p = 0.01). Mean duration of postoperative ventilatory support was 36 ± 53 min (range 20–130 min). The need for ventilatory support did not correlate with cholinesterase inhibitor demand or muscle relaxant used for intubation. Re-intubation was never necessary. No pulmonary complications occurred in either group. All patients with TEA could be transferred to a
normal ward after a short PACU stay, therefore bypassing intensive care or intermediate care units. **Conclusion(s):** The use of TEA for analgesia during anaesthesia reduces the need for prolonged postoperative mechanical ventilation in myasthenia gravis patients, doesn’t increase the risk of pulmonary complications and may lessen costs by reducing the need for postoperative intensive or inter- 

### A-414

**Patient controlled epidural analgesia for major urologic surgery. Influence of different dosage regimen on quality of analgesia, side effects and economics**

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**Department of Anaesthesiology, University Hospital Dresden, Dresden, Germany**

**Background and Goal of Study:** The efficiency of patient controlled epidural analgesia (PCEA) following major surgery has been demonstrated. Additional beneficial effects like abdominal or thoracic sympathicolysis which play a major role within multimodal clinical pathways have not been considered in previous studies. The purpose of the present study was therefore to evaluate differences in quality of analgesia, unintended as well as beneficial side effects, and economics using different dosage regimes for PCEA.

**Materials and Methods:** After institutional approval and written informed consent 120 patients undergoing major urological surgery in combined general and epidural anaesthesia were randomly assigned to 3 groups: group 1 basal infusion rate (BR) 0 ml/h, group 2 BR 5 ml/h und group 3 BR 10 ml/h. In all groups patient-controlled bolus application of 5 ml was possible. Ropivacaine 0.2% and sufentanil 0.5 μg/ml were used. For a minimum of 72 hours quality of analgesia was assessed by visual analog scale (VAS), blood pressure and heart rate, onset of bowel sounds and defecation, as well as unintended side effects (drowsiness, nausea, pruritus) were recorded.

**Results and Discussions:** 114 patients underwent complete observation. Groups did not differ regarding patients characteristics and duration of surgery. Hypotension was more common during the first 12 hours in group 1 and 2 (fig. figure). There were no differences regarding quality of pain relief and onset of bowel sounds and first defecation. The amount of analgesic drugs required and therefore costs of pain relief differed significantly [left figure]. Patients in group 1 suffered more drowsiness and fatigue.

**Conclusion(s):** In patients undergoing major urological surgery the use of different basal infusion rates for PCEA provide a similar quality of pain relief and return of gastrointestinal function. However, using no or low BR reduces the incidence of undesired side effects as well as hospital costs.

### A-415

**Bacterial contamination of epidural catheters used for combined spinal-epidural analgesia**

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**Department of Anaesthesia, St James University Hospital, Leeds, United Kingdom**

**Background:** The aim of this study was to explore the bacteria presents on epidural catheters (EC) during combined spinal epidural analgesia (CSE) after three days stay.

**Methods:** Prospective, randomized study was designed to compare two different approaches for CSE: thoracic EC (TEC) (T6-7) for patients undergoing upper abdominal surgery and spinal (L2-3) and CSE “needle technique” which was performed in patients (pts) undergoing colorectal surgery in L2-3 interspinous space (LEC). The skin preparation was performed by alchohol and povidone iodine applied with an abrasive sponge and in widening circle manner outward from the periphery. Epidural bupivacaine 0.25% was started preoperatively (10 ml) and was continued during surgery. EC were removed 72 hours after placement by sterile technique. The part of the catheter from tip to skin was incubated in sterile tube and transferred to the laboratory. EC were rinsed in 1% dextrose. After 10 hours incubation period on 37°C, all materials were spread out on blood agar and incubated at 37°C for 10 days. Differential analysis of microorganisms was performed after incubation using morphological, physiological and serological criteria. Data analysis was performed by Chi square test. P < 0.05 was considered as significant.

**Results:** Epidural punction was successful after first attempt in 34.6% (27/78) in thoracic region and 67.9% (53/78) in lumbar region. The maximum number of TEC attempts was 9. Significantly greater number of epidural punctions was in TEC (3 vs 1, Chi square test, p = 0.003), TEC 78.2% (61/78) and LEC 74.4% (58/78) were sterile. Staphylococcus epidermidis was isolated on 19.2% of EC in both groups (15/78), Accinobacter spp was isolated in 1.3% of EC in both groups (1.3%). Enterobacter spp was isolated on 1.3% (1/78) LEC. Staphylococcus aureus was present in 1.3% (1/78) TEC and 2.6% (2/78) in LEC. Escherichia coli was present in 1.3% (1/78) in LEC. No infection on punction sites neither meningitis nor epidural abscesses were recorded in these patients. There is no significant difference between groups in bacterial presentation on epidural tips in TEC and LEC (Chi square test, p = 0.640).

**Conclusion:** Although the number of epidural punction attempts was significantly greater in thoracic group, the number of contaminated EC was greater in lumbar group. This finding suggest that kind of operation as colorectal surgery had influence. We suggest routine catheter check whenever CSE technique is employed.

### A-416

**Ropivacaine vs. Bupivacaine for epidural PCA. The incidence of urinary retention assessed by bladder ultrasound, a randomized controlled study**


**Department of Anesthesiology and Intensive Care Medicine, Carmel Lady Davis Medical Center, Haifa, Israel**

**Background and Goal of Study:** Epidural PCA (EPCA) may cause urinary retention [1]. We hypothesized that use of Ropivacaine (Rop), a local anesthetic with less motor blockade [2] than Bupivacaine (Bup) and with no opioids added [3] will be associated with less urinary retention.

**Materials and Methods:** After ethical committee approval and informed consent, 72 patients undergoing joint arthroplasty under general anaesthesia, with no previous urinary problems were included and randomly assigned to one of three groups of EPCA: Rop (0.2%) from 8 to 10 cc/h; Bup 0.125% with Fentanyl (F) 5 mcg/cc 4 to 6 cc/h; and Rop (0.2%) with F 5 mcg/cc 4 to 6 cc/h. Urinary bladder volume was determined using the ultrasound scanner and a volume of 400 cc was used as threshold for catheterization. Categorical variables were compared between the 3 treatment groups using the Chi-square test and Fisher exact test. Data presented as mean ± SD.

**Results and Discussions:** Urinary retention was found in 34.7% of the patients. Analgesia was adequate and similar in all three groups. There was no difference in the incidence of urinary retention or motor block between all three groups (Table).

<table>
<thead>
<tr>
<th>Variables</th>
<th>Rop</th>
<th>Bup + F</th>
<th>Rop + F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender (F/M)</td>
<td>15/9</td>
<td>15/9</td>
<td>14/10</td>
</tr>
<tr>
<td>Age</td>
<td>67.46 ± 9.1</td>
<td>72.67 ± 9.8</td>
<td>74.29 ± 8.0</td>
</tr>
<tr>
<td>Urinary bladder, volume (ml)</td>
<td>412 ± 271</td>
<td>412 ± 384</td>
<td>434 ± 337</td>
</tr>
<tr>
<td>Urinary catheterization</td>
<td>9/24 (37.5%)</td>
<td>8/24 (33.3%)</td>
<td>8/24 (33.3%)</td>
</tr>
<tr>
<td>Maximum VAS</td>
<td>5 ± 3</td>
<td>3 ± 3</td>
<td>3 ± 2</td>
</tr>
</tbody>
</table>

**Conclusion(s):** No advantages were found for using Ropivacaine. Epidural opioids did not influence the incidence of urinary retention. The urinary bladder scan might be useful to assess post-operative urinary retention.

**References:**
A-417
Parasacral sciatic nerve block: Which component to stimulate?
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Background and Goal of Study: Mansour described an approach to the sciatic nerve block that is easy to perform and to teach (1). The aim of this prospective randomised double blind study was to compare the efficacy of the block performed by this approach when stimulation was obtained either by the tibial or the peroneal motor response.

Materials and Methods: After local ethics committee approval, 26 ASA I–3 patients scheduled for elective lower limb surgery who gave informed consent were included. Patients were randomised to receive a parasacral sciatic nerve block, as described by Mansour’s technique, using a nerve stimulator (intensity < 0.5 mA, time 100 μs, frequency 1 Hz), looking for tibial or peroneal motor response (Group 1: N = 14) or peroneal motor response (Group 2: N = 12). After the desired motor response was obtained, a solution of 10 ml 2% lidocaine with epinephrine 1/200 000 and 10 ml 0.75% ropivacaine was slowly injected through the needle. Sensory and motor blocks were assessed every 5 min during 30 min by an anaesthesiologist blinded to the type of motor response that was elicited. If the block was not complete 30 min after injection of the local anesthetics, it was considered as having failed, and anaesthesia was supplemented with intravenous agents.

Results and Discussions: The success rate for complete block was higher in group 1 than in group 2. This difference was significant (p = 0.002). This difference was established between 4 and 8 hours postoperatively. There were also significantly more patients reporting severe pruritus in group S compared to group P (p = 0.024). This difference was established between 4 and 8 hours postoperatively. There were also significantly more patients reporting severe pruritus in group S compared to group P (p = 0.03). Conclusion: Propofol used for induction and maintenance of anaesthesia may reduce the incidence and severity of pruritus induced by epidural morphine, the first 8 hours postoperatively.

References:

A-418
Phantom pain after amputation: Interest of preoperative regional anaesthesia?
F. Decamps, C. Pellé, E. Robin, M. Fleyfel, B. Thielemans, P. Scherperee
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Introduction: 60% of amputees suffer from phantom limb pain within the first week after amputation and pain remain incapacitating from 10% to the first year. Preoperative epidural blockade may reduce the incidence of phantom pain. However, when patients are under anticoagulant or antiagregant therapy, epidural analgesia may appear hazardous. The regional analgesia by peripheral block may be a solution.

Materials and Methods: After approval by the Hospital Ethical Committee, 50 patients were scheduled for lower limb amputation, because of ischemic disease. They were allocated in two groups randomised: group A (n = 23) received a regional anaesthesia with blockade of the lumbar plexus (posterior approach) and blockade of the sciatic nerve by ropivacaine 7.5 mg/ml, just before the general anaesthesia, group B (n = 27) received general anaesthesia. Both groups had the same post operative analgesia, using propacetamol and morphine.

Each patient was asked about preamputation pain, phantom and stump pain (visual analogy score was recorded) after one day, seven days, one month and three months after amputation.

Results: There was no significant difference for the both group for the phantom limb and stump pains in all periods. There was no difference in the onset between groups at any of the postoperative assessments for phantom limb pain. There was a significant relation between preamputation pain and stump pain at one day (p = 0.046) and seven days (p = 0.014).

Conclusion: Preoperative regional analgesia does not decrease the incidence of phantom limb and stump pains until three months. Preamputation pain significantly increases the incidence of stump pain at one and seven days.

References:

A-419
Propofol versus sevoflurane in the prevention of epidural morphine-induced pruritus
A. Pandazi, P. Matsota, S. Matiatou, S. Kontogianopoulou, G. Grigoropoulos, G. Kostopanagiotou
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Background and Goal of Study: We examined the efficacy of intraoperative propofol administration to prevent pruritus induced by epidural morphine.

Materials and Methods: Seventy patients ASA I and II undergoing combined epidural and general anaesthesia for hysterecomy participated in this prospective, randomised study. They were randomly assigned to two groups: the group in which anaesthesia was induced with propofol and fentanyl, and maintained with propofol–N2O (group P), and the group in which anaesthesia was induced with thiopental and fentanyl and maintained with sevoflurane–N2O (group S). All patients received 3 mg epidural morphine bolus one hour before the end of surgery. The incidence and severity of pruritus were evaluated every 4 hours for the first 12 hours postoperatively by blinded observers.

Results and Discussions: The total incidence of pruritus was significantly higher in group S compared to group P (p = 0.024). This difference was established between 4 and 8 hours postoperatively. There were also significantly more patients reporting severe pruritus in group S compared to group P (p = 0.03).

Conclusion: Propofol used for induction and maintenance of anaesthesia may reduce the incidence and severity of pruritus induced by epidural morphine, the first 8 hours postoperatively.

References:

A-420
MLAC Determination of Levobupivacaine in continuous femoral nerve block for analgesia after total knee replacement
S. Lalieu, E. Dereeper, M. Sosnowski
Department of Anaesthesia, CHU Saint-Pierre, Brussels, Belgium

Background and Goal of Study: Excellent postoperative analgesia after total knee replacement (TKR) could be achieved by a continuous femoral
nerve block (FNB). The local anesthetic concentration should be adjusted to provide adequate pain relief, while preventing side effects and useless motor block. We designed this study to determine the minimal local anesthetic concentration (MLAC) of Levobupivacaine in a continuous FNB after TKR.

Materials and Methods: After approval of our local ethic committee, 25 consecutive ASA 1–3 patients aged 60 to 85 years were included in this study. Under light sedation, we performed a FNB, inserted a perineural catheter (Contiplex 50 mm, B. Braun, Germany) and administered 3 ml/kg of Levobupivacaine 0.5% with epinephrine 1:200000. After completion of anesthesia, the first enrolled patient received a PCA device with a 0.15% concentration of Levobupivacaine running at 5 ml/h (and 5 ml boluses). For the other patients, we used the Dixon’s sequential allocation method; briefly: if visual analogical scale (VAS) pain score became greater (stayed lower) than 4, at any time during the first 36 hours for the anterior knee area, analgesia was estimated insufficient (sufficient) and the next patient would then receive an incremental (decreased) dosage concentration of 0.025%.

Results and Discussion: The successive concentrations administered are presented in figure. Calculated ED50 or MLAC Levobupivacaine for postoperative analgesia was 0.082%. Derived ED95 was 0.065% in our study ($R^2 = 0.99$).

Conclusion: The minimal effective local anesthetic concentration of Levobupivacaine for perineural postoperative analgesia after TKR is 0.065%.


A-422
MLAC Determination of Ropivacaine in continuous femoral nerve block for analgesia after total knee replacement

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Background and Goal of Study: Excellent postoperative analgesia after total knee replacement (TKR) could be achieved by a continuous femoral nerve block (FNB). The local anesthetic concentration should be adjusted to provide adequate pain relief, while preventing side effects and useless motor block. We designed this study to determine the minimal local anesthetic concentration (MLAC) of Ropivacaine in a continuous FNB after TKR.

Materials and Methods: After approval of our local ethic committee, 22 consecutive ASA 1–3 patients aged 60 to 85 years were included in this study. Under light sedation, we performed a FNB, inserted a perineural catheter (Contiplex 50 mm, B. Braun, Germany) and administered 3 ml/kg of Ropivacaine 0.5% with epinephrine 1:200000. After completion of anesthesia (Propofol Sufentanil), the first enrolled patient received a PCA device with a 0.2% concentration of Ropivacaine running at 5 ml/h (and 5 ml boluses). For the other patients, we used the Dixon’s sequential allocation method, briefly: if visual analogical scale (VAS) pain score became greater (stayed lower) than 4, at any time during the first 36 hours for the anterior knee area, analgesia was estimated insufficient (sufficient) and the next patient would then receive an incremental (decreased) dosage concentration of 0.025%.

Results and Discussion: The successive concentrations administered are presented in figure. Calculated ED50 or MLAC Ropivacaine for postoperative analgesia was 0.062%. Derived ED95 was 0.065% in our study ($R^2 = 0.99$).

Conclusion: The minimal effective local anesthetic concentration of Ropivacaine for perineural postoperative analgesia after TKR is 0.115%.


A-423
Using stimulating or nonstimulating catheters for continuous peripheral nerve block. A prospective randomized, blind investigation

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Background and Goal of Study: We tested the hypothesis that a stimulating catheter-guided perineural placement improves the efficacy of postoperative analgesia as compared to a conventional sham nonstimulating technique.

Materials and Methods: With ethic committee approval and written consent we studied 100 patients, undergoing continuous popliteal sciatic nerve block for orthopedic foot surgery. After eliciting a sciatic mediated response stimulating through an introducer needle at <0.5 mA, the perineural catheter was inserted 2–4 cm beyond the tip of the introducer either blindly (group Control, n = 50) or while stimulating via the catheter (group Stimulating, n = 50). If foot twitches decreased or disappeared during insertion, the catheter position was adjusted until eliciting adequate foot movements at <1 mA. Surgical block was induced with 30 mL of 1.5% mepivacaine, and postoperative analgesia maintained with propacetamol 2 g IV every 8 hours and a patient-controlled infusion of 0.2% ropivacaine (basal infusion: 3 mL/h; incremental dose: 5 mL; lock-out time: 20 min with maximum 2 boluses per hour). Opioid rescue analgesia was available if required.

Results and Discussions: No differences in quality of pain relief at rest and during motion were reported between the two groups. Local anesthetic consumption during first 24 h was 122 ± 26 mL in group Stimulating and 148 ± 39 mL in group Control (P = 0.04). No further differences in local anesthetic consumption were reported during the 2nd day. Rescue opioid analgesia was required by 28 patients of group Control (57%) and 12 patients of group Stimulating (25%) (P = 0.004).

Conclusion(s): We conclude that direct confirmation of correct catheter placement results in shorter onset time of sciatic nerve block, less postoperative consumption of local anesthetic, and less needs for rescue pain medication.

A-424
Infection following epidural catheterization: Risk factors

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Background and Goal of Study: Systemic and deep infection is a rare complication derived from the use of epidural catheters (EC) for postoperative analgesia (range from 0 to 0.7%). The aim of our study was to determine the incidence of colonization of EC tips and its correlation both with clinical infection and patient’s risk factors.

Materials and Methods: We prospectively studied 108 adult surgical patients (6 ASA I, 44 ASA II, 56 ASA III, 2 ASA IV) undergoing postoperative epidural analgesia. They were reviewed twice a day and the EC tips were semiquantitatively cultured after removal. Insertion site, body temperature, surgical block was induced with 30 mL of 1.5% mepivacaine, and postoperative analgesia maintained with propacetamol 2 g IV every 8 hours.

Results and Discussions: Mean time of EC removal was of 69 ± 24 hours. The incidence of positive cultures was of 23.6%. Of all positive cultures, 1 patient (3.7%) showed erythema in the insertion site (p = 0.33), 17 patients (88%) had leukocytosis (p = 0.44) and 6 (25%) had fever (p = 0.41). No serious systemic infection was recorded. Significant risk factors associated with culture’s results are summarized in the table:

<table>
<thead>
<tr>
<th>CRF</th>
<th>CC</th>
<th>EMERG</th>
<th>PROGR</th>
</tr>
</thead>
<tbody>
<tr>
<td>−culture</td>
<td>9 (56%)</td>
<td>6 (24%)</td>
<td>8 (32%)</td>
</tr>
<tr>
<td>+culture</td>
<td>8 (9%)</td>
<td>3 (4%)</td>
<td>11 (14%)</td>
</tr>
<tr>
<td>p = 0.02</td>
<td>p = 0.01</td>
<td>p = 0.036</td>
<td></td>
</tr>
</tbody>
</table>
Conclusion(s): In short term EC we did not find a significant correlation between positive tip cultures and clinical signs of infection. Patients with chronic renal failure, corticosteroid treatment and those undergoing emergency surgery showed a greater incidence of EC tip contamination. In these group of patients, special antiseptic care could be recommended.

References:

A-424
Implementing thoracic epidural analgesia for postoperative pain relief within a clinical pathway reduces the incidence and severity of early non-surgical complications in patients undergoing open radical prostatectomy

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Background and Goal of Study: Methods of pain relief, which offer both anaesthesia and sympatholysis can attenuate stress related side effects following surgery and consequently play a major role within modern clinical pathways. In 1993 a collaborative clinical pathway was established at our institution, including: standards for surgery, transfusion regime, postoperative care and postoperative pain relief. The purpose of the underlying study was therefore to evaluate the impact of this method of pain relief on incidence and severity of non-surgical complications in patients undergoing radical retropubic prostatectomy.

Material and Methods: The records of 1165 consecutive patients receiving radical retropubic prostatectomy between 1994 and 2002 were analysed regarding co-existing diseases and incidence and severity of any kind of postoperative non-surgical complications. Patients received thoracic or lumbar epidural anaesthesia (TEA or LEA) or alternatively patient controlled intravenous opioid analgesia (PCIA) if contraindications or refusal for epidurals existed.

Results: Three different methods of analgesia were applied: TEA, LEA or PCIA. There were no differences regarding demographic data, patient characteristics, duration of surgery, and blood loss between groups. However, cardiopulmonary complications were significantly reduced in the TEA group (table) as well as overall minor and major complications.

Results:

<table>
<thead>
<tr>
<th>Complication</th>
<th>TEA</th>
<th>PCIA</th>
<th>LEA</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac complication</td>
<td>3.0%</td>
<td>6.7%</td>
<td>7.3%</td>
<td>0.01</td>
</tr>
<tr>
<td>Myocardial infarction</td>
<td>0.2%</td>
<td>0.9%</td>
<td>0.9%</td>
<td>0.1</td>
</tr>
<tr>
<td>Pulmonary comp.</td>
<td>2.6%</td>
<td>6.7%</td>
<td>10.1%</td>
<td>0.001</td>
</tr>
<tr>
<td>Pulmonary embolism</td>
<td>0.5%</td>
<td>0.5%</td>
<td>0.9%</td>
<td>n.s.</td>
</tr>
<tr>
<td>Neurological</td>
<td>1.3%</td>
<td>1.3%</td>
<td>5.5%</td>
<td>0.06</td>
</tr>
<tr>
<td>Delayed mobilisation</td>
<td>1.4%</td>
<td>0.4%</td>
<td>25.7%</td>
<td>0.001</td>
</tr>
<tr>
<td>ICU-admission</td>
<td>3.0%</td>
<td>7.1%</td>
<td>4.5%</td>
<td>0.01</td>
</tr>
</tbody>
</table>

Conclusions: As compared to LEA and PCIA thoracic epidural analgesia provided a striking benefit in reducing early non-surgical complications and unplanned ICU admission in radical prostatectomy patients.

A-425
Compatibility of regional anesthesia with low molecular weights heparins and thrombembolism prophylaxis

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Background and Goal of Study: Deep venous thrombosis and fatal pulmonary embolism are common and serious complications after orthopedic surgery, considered a high-risk surgery. The goal of performing regional anesthesia to patients receiving preoperative thrombembolism prophylaxis or in whom this should be initiated postoperatively is still controversial. Spinal hematoma is a rare complication of spinal or epidural anesthesia but potentially catastrophic in the absence of an immediate treatment.

Material and Method: We studied the compatibility of regional anesthesia with the thrombembolism prophylaxis, represented by the spinal hematoma incidence in patients undergoing orthopedic lower member surgery from November 1999 to October 2004, in our hospital. From the 5303 patients, 3486 (65.67%) have begun the first LMWH at 6–8h postoperatively, while 880 bed-needled patients (15.46%) have received LMWH preoperatively; in this group the last LMWH dose had been administered 12h before the spinal puncture; the next LMWH dose at 6–8h postoperatively.

Results: The incidence of spinal hematoma was zero, irrespective of the regimen of LMWH administration.

Conclusion: In the absence of European guidelines, our experience shows that preoperative (12h) or postoperative (6h) administration of LMWH in 5303 patients receiving spinal/epidural anesthesia was safe and not complicated by spinal hematoma.

References:

A-426
Systematic review of nerve block and incisional local anaesthetics for analgesia in herniography

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Background and Goal of Study: The PROSPECT initiative is a collaboration of surgeons and anaesthesiologists that provides evidence-based recommendations for PROCedure-SPECific pain management.1 Given that local anaesthetic techniques are widely used for analgesia in herniography, PROSPECT examined the evidence to support this practice.

Materials and Methods: Systematic literature review (1966–January 2004) using the Cochrane protocol; randomised trials in adult herniography of inguinal nerve block (INB) or wound infiltration (WI) using local anaesthetics (LA) vs. placebo (or pre- vs. post-incisional administration) reporting pain scores (VAS 1–100 mm). Where possible, data were grouped and weighted mean differences (WMD) and odds ratios (OR) calculated.

Results: Total number of studies (n = 16; 20–100 patients per study. Pre-incisional INB vs. placebo (n = 7). Reduction in: VAS scores at rest 0–6h (n = 6) and 48h (n = 1) but not 8–24h (n = 2), WMD at 3h – 18.21 p = 0.002 (n = 2); VAS scores on movement 3–10h (n = 1) and 1–24h (n = 1); and morphine use WMD – 4.58 mg/24h p = 0.04 (n = 3).

Intra-operative INB + intra- + postoperative WI vs. placebo (n = 2). Reduction in: VAS scores on lying, sitting and walking for 0h–10 days (n = 1) and at rest for 0–24h (n = 1); and supplementary analgesic use (n = 2).

Intra-operative WI vs. placebo (n = 4). Reduction in: pain at rest at 1–3h (n = 3), 5, 12 (n = 1), and 48h (n = 1) but not 4, 6 (n = 1), 5 (n = 1) or 24h (n = 1) or 10 days (n = 1). VMD at 3h – 35.83 p = 0.006 (n = 2); pain on movement 4, 6 (n = 1), 24 and 48h (n = 1); and number of analgesic tablets WMD – 0.65 p = 0.01 (n = 2).

Post- vs. post-incisional INB or WI (n = 3). Non-significant for pain scores (n = 3); or supplementary analgesic use (n = 2 out of 3).

Conclusion(s): This review supports the current clinical practice of using local anaesthetic techniques for analgesia in herniography, and shows that they provide significant and clinically meaningful reductions in pain regardless of whether they are given pre-, intra- or postoperatively.

Reference:

A-427
Can local techniques for anaesthesia improve patient outcome following hernia repair?

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Background and Goal of Study: PROSPECT provides evidence-based recommendations for PROCedure-SPECific postoperative pain management, through collaboration of an international Working Group of surgeons and anaesthesiologists.1 PROSPECT presents a systematic review on the postoperative analgesic effects of local anaesthesia in adult herniography.

Materials and Methods: Systematic literature review (1966–January 2004) using the Cochrane protocol; randomised trials in herniography of local techniques for anaesthesia (nerve block and wound infiltration with local anaesthetics (LA) vs. other anaesthetic techniques, reporting pain scores (VAS 1–100 mm); where possible, data were grouped and weighted mean difference (WMD) and odds ratios (OR) calculated.

Results: Total number of studies (n = 8). All local techniques were ilioinguinal and iliohypogastric nerve blocks plus wound infiltration. For spinal studies; one used LA plus strong opioid, another LA alone and two did not specify; one spinal group included 18% epidurals.

Results:

<table>
<thead>
<tr>
<th>Pain at Rest, VAS (mm)</th>
<th>TEA</th>
<th>PCIA</th>
<th>LEA</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–1h</td>
<td>3.0%</td>
<td>6.7%</td>
<td>7.3%</td>
<td>0.01</td>
</tr>
<tr>
<td>2–6h</td>
<td>0.2%</td>
<td>0.9%</td>
<td>0.9%</td>
<td>0.1</td>
</tr>
<tr>
<td>7–12h</td>
<td>2.6%</td>
<td>6.7%</td>
<td>10.1%</td>
<td>0.001</td>
</tr>
<tr>
<td>13–24h</td>
<td>0.5%</td>
<td>0.5%</td>
<td>0.9%</td>
<td>n.s.</td>
</tr>
<tr>
<td>25–48h</td>
<td>1.3%</td>
<td>1.3%</td>
<td>5.5%</td>
<td>0.06</td>
</tr>
<tr>
<td>49–72h</td>
<td>1.4%</td>
<td>0.4%</td>
<td>25.7%</td>
<td>0.001</td>
</tr>
<tr>
<td>73–96h</td>
<td>3.0%</td>
<td>7.1%</td>
<td>4.5%</td>
<td>0.01</td>
</tr>
</tbody>
</table>

Conclusions: As compared to LEA and PCIA thoracic epidural analgesia provided a striking benefit in reducing early non-surgical complications and unplanned ICU admission in radical prostatectomy patients.
Local vs. general anaesthesia ($n = 7$). Local anaesthesia reduced: VAS scores in 6/7 studies at different times up to 8 days, WMD at 1 h – 19.51 p = 0.00001 (2 studies), WMD at 24 h – 4.38 p = 0.04 (3 studies); post-operative nausea and vomiting OR 0.19 p < 0.00001 (5 studies); sore throat OR 0.14 p < 0.0001 (3 studies), and hospital stay WMD – 3.10h p < 0.00001 (2 studies).

Local vs. spinal anaesthesia ($n = 4$). Local anaesthesia reduced maximum VAS scores in 3/4 studies at different times up to 30 days, reduced hospital stay WMD – 3.10h p < 0.00001 (2 studies), and produced less urinary retention OR 0.02 p < 0.00001 (3 studies).

Conclusion(s): In herniography, local anaesthesia with nerve block and infiltration has superior postoperative analgesic and recovery benefits compared with general or spinal anaesthesia.

References:

A-428
Single injection paravertebral block prevents from chronic pain after breast cancer surgery
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Background and Goal of Study: Chronic pain symptoms are prevalent after breast surgery (1). Preincisional paravertebral block (PVB) provides significant immediate postoperative analgesia (2) possibly reducing the incidence of chronic pain. Therefore, a one-year follow-up was performed.

Material and Methods: A prospective, randomized, placebo controlled and blinded outcome study in 60 patients who underwent breast surgery for cancer was conducted. Before general anaesthesia 30 patients were given a PVB with bupivacaine and 30 patients a sham block with saline (SHAM). The follow-up consisted of a 14-day symptom diary and telephone interviews 1, 6 and 12 months after the operation. The data were analysed using Kruskal-Wallis or Chi-square tests.

Results and Discussions: During the first two weeks the overall consumption of analgetics was similar in both groups. One month after the operation there was less movement related pain [median 2(range 0–7) vs. 4(0–10)] (p = 0.005) and a lower incidence of nausea and vomiting (0 vs. 5 patients) (p = 0.02) in the PVB group. There were no significant differences between the groups at 6 months after the operation when most patients were having chemotherapy or radiotherapy. However, 12 months postoperatively there were less pain (Table) and other symptoms in the PVB than the SHAM group:

<table>
<thead>
<tr>
<th>Pain</th>
<th>Number</th>
<th>P-value</th>
<th>Intensity (0–10)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>At rest</td>
<td>1 vs. 8</td>
<td>0.03</td>
<td>0(0–1) vs. 0(0–8)</td>
<td>0.01</td>
</tr>
<tr>
<td>In motion</td>
<td>9 vs. 18</td>
<td>0.05</td>
<td>0(0–6) vs. 2(0–8)</td>
<td>0.003</td>
</tr>
<tr>
<td>Sharp</td>
<td>3 vs. 12</td>
<td>0.02</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurpathic</td>
<td>2 vs. 3</td>
<td>0.64</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum</td>
<td>5(0–10) vs. 8(0–10)</td>
<td>0.04</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Conclusions: In addition to providing acute postoperative pain relief (2), preoperative PVB seems to prevent painful conditions still one year after breast cancer surgery. These extended benefits should encourage a more extensive use of PVB analgesia associated with breast cancer surgery.

References:

A-429
Fast-track colonic surgery: First experience in a French hospital care
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Introduction: Multimodal rehabilitation programs after colonic surgery have been proposed to shorten postoperative stay and therefore decrease morbidity, primarily thought to be linked to postoperative ileus (1). The aim of this study was to evaluate such a fast track program in a non-teaching hospital with a nurse/patient ratio of 1/10.

Patients and Method: 38 consecutive patients were included in a fast track colonic surgical program consisting of a conventional resection surgery, lack of drain, continuous thoracic epidural analgesia, restricted intravenous (IV) fluids administration, early oral nutrition, enforce mobilization, planned over the 4 post-operative day. Morbidity and hospital length of stay were assessed during the five postoperative day. Results are expressed as median (range) or percentage.

Results: Age and ASA score were 74 years (30–92) and 2 (1–3) respectively. Epidural catheter was withdrawn on day 2 (1–5) and bladder drain on day 1 (0–5). Gaz and defecation occurred respectively on day 1 (0–5) and day 2 (0–5). 47% of patients had postoperative nausea. Pain at cough and fatigue scores were 3 (0–10) and 6 (0–10), respectively. IV postoperative fluids were not used in 21 (55%) patients. Postoperative variation of serum creatinine was low (15μmol/l) and not dependent on patient’s age or the use of post-operative IV fluid administration. Patients were ready to be discharged on the 4.5 (4–11) day. However, actual hospital length of stay was 6 days (4–11). Incidence of anastomotic leak was 8% (3) and infectious disease was 10.5% (4).

No readmission was recorded.

Conclusion: As reported in other recent studies (2), fast track colonic surgery was not associated to a high incidence of surgical, infectious or renal complications. This fast track procedure has the ability to shorten the hospital stay despite a low nurse/patient ratio.

References:
A-432
Impact of thoracic epidural analgesia on revenue using G-DRG M01B, OPS-301 5-604.0 (radical retroperitoneal prostatectomy)
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Background and Goal of Study: The recent introduction of the diagnosis related healthcare reimbursement system G-DRG in Germany initiates a previously unknown competition within the public healthcare system aiming towards a reduction of cost-intensive over-capacities. Accordingly, the patient-oriented optimization of operative processes and a simultaneous increase of quality and patient satisfaction became a vital interest of health-care providers. Using the surgical procedure OPS 5-604.0 (radical retroperitoneal prostatectomy) as an example our study identifies revenue-relevant patient characteristics and describes the impact of the perioperative application of thoracic epidural analgesia (TEA).

Materials and Methods: Factors affecting duration of stay were determined in 460 patients undergoing OPS 5-604.0 in the year 2001 and 2002 using multivariable regression analysis. Preoperative parameters served as factors for matched pair analysis of the effects of TEA.

Results: Characteristics significantly affecting length of postoperative hospital stay were ASA-status, age, preoperative haemoglobin concentration, post operative tachycardia, number of transfused packed red cells, wound infection and surgical revision procedures. Based upon identical matching criteria 27 pairs (with/without TEA) could be formed. While the induction time in the TEA-group was 8 ± 18 min longer (p = 0.04), emergence was briefer by 3 ± 9 min (p = 0.05). Neither duration of anaesthesia nor anaesthesia presence time or anaesthesia costs (TEA €489 ± 87/QA €456 ± 83) differed significantly between the pairs. In contrast, the postoperative length of hospital stay after TEA was reduced by 1.6 ± 2.8 days (p = 0.007), which was accompanied by an extended duration of pain therapy, corresponding with an total increase of efficiency by around 12.5%. If this increase is used for an increase in the number of OPS 5-604.0 procedures, then excesses proceeds with a value of €207,040 per annum can be expected.

Conclusion: At first sight combined anaesthesia procedures require more human resources and material, which, however, play a minor role in calculation of total case costs. As a result of shortened hospital stay and optimized pain therapy “customer satisfaction” increases and leads to a substantial potential for increased revenue.

A-434
Continuous interscalene brachial plexus block (CIBPB) is the analgesic technique of choice after minor open shoulder surgery
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Background and Goal of Study: The use of CIBPB after minor open shoulder surgery remains questionable. The aim of the present prospective, randomised, blinded study was to compare 3 different analgesic techniques after such a surgery.

Materials and Methods: Thirty patients scheduled for open supraspinatus muscle tendon repair under general anaesthesia were divided into 3 groups. In G1, no block was performed; in G2, a single shot interscalene block with 20 ml 0.5% ropivacaine + epinephrine; and in G3, a CIBPB with a bolus dose of 20 ml 0.5% ropivacaine + epinephrine followed by a continuous infusion of 0.2% ropivacaine at 7 ml·h⁻¹. An iv PCA with morphine (1 mg – 7 min) was available for rescue analgesia in all patients. Pain intensity at rest and on movement (VAS: 0 = no pain; 100 = severe pain), morphine consumption, side-effects, and patients’ satisfaction score were recorded at 4, 24 and 48 h. Results are expressed as mean ± SD. P < 0.05 was considered significant.

Results and Discussions: Interscalene block was successful in all patients in G2 and G3. No difference in demographic data and side-effects was found between the groups. When compared with G1, pain scores and morphine consumption were lower in G3 (Table 1). When compared with G2, morphine consumption at 24 and 48 h was lower in G3. Patient’s satisfaction was higher in group 3 when compared with G1 (71 ± 22, 86 ± 11 and 94 ± 11 in groups 1, 2 and 3 respectively).

Conclusion(s): After minor open shoulder surgery, CIBPB is the analgesic technique of choice. Single shot interscalene block provides efficient but too short lasting analgesia.

Table 1.

<table>
<thead>
<tr>
<th></th>
<th>Group 1</th>
<th>Group 2</th>
<th>Group 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>VAS 12 h</td>
<td>4 h</td>
<td>33 ± 20</td>
<td>16 ± 17</td>
</tr>
<tr>
<td></td>
<td>24 h</td>
<td>35 ± 18</td>
<td>30 ± 19</td>
</tr>
<tr>
<td></td>
<td>48 h</td>
<td>18 ± 14</td>
<td>11 ± 9</td>
</tr>
<tr>
<td>VAS 48 h</td>
<td>4 h</td>
<td>49 ± 28</td>
<td>28 ± 27</td>
</tr>
<tr>
<td></td>
<td>24 h</td>
<td>58 ± 16</td>
<td>52 ± 19</td>
</tr>
<tr>
<td></td>
<td>48 h</td>
<td>40 ± 19</td>
<td>32 ± 18</td>
</tr>
<tr>
<td>Morphine 12 h</td>
<td>4 h</td>
<td>19 ± 13</td>
<td>5 ± 7</td>
</tr>
<tr>
<td></td>
<td>24 h</td>
<td>38 ± 11</td>
<td>33 ± 20</td>
</tr>
<tr>
<td></td>
<td>48 h</td>
<td>49 ± 20</td>
<td>54 ± 35</td>
</tr>
</tbody>
</table>

(*group 3 vs group 1; |group 3 vs group 2)
A-435

Auxiliary plexus block according to Weber is more effective than Bütter’s method in supine position

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Background and Goal of Study: Using the auxiliary brachial plexus block (AP) according to Weber with lateral positioning combined with 20° Trendelenburg positioning is possible to reach more proximal nerves (1) than with Bütter’s method in supine position (2). It is not clear whether the two methods are equally efficient. Therefore, in this prospective, randomized, single-blind study we compared the sensory and motoric quality, spread and time to obtain a complete block, tourniquet, frequency of supplemented nerve blocks and the need for general anaesthesia.

Materials and US-guided: After a positive vote of the local Ethics Committee 108 patients undergoing hand surgery were separated into 2 groups: B (Bütter) and W (Weber). The block was performed (using a nerve stimulator) with 45 mL mepivacaine 1% (MEPI1%) and NaHCO3 (1:10). The musculocutaneous nerve was separately blocked with 5 mL MEPI1%. Only in group W patients were positioned onto the anaesthetized side for 30 minutes according to Weber. Incomplete blocks were supplemented 30 min after the initial block.

Results: A greater success rate of a complete sensory block was found in group W (88,9% * vs. 71,3%). Incomplete blocks were more successfully supplemented in group W (8,3% * vs. 19,4%). The need for general anaesthesia was lower in group W (2,8% * vs. 9,3%). Only in group W a complete sensory block of axillary nerve (NA) occurred (65,7% * vs. 0,0) and 21,3% vs. 13,9% of incomplete sensory block was found. Motor blocks of the NA (74,11% * vs. 0,0), of the thoracodorsal nerve (NT) in (64,8% * vs. 0,0), and the subscapular nerve (NS) (74,11% * vs. 0,0), occurred only in group W.

Statistics: Chi-quadat-test corrected by Yates ( p < 0,05; sign. = *, p < 0,001; sign. = **).

Conclusion: The auxiliary brachial plexus block according to Weber with positioning onto the anaesthetized side need the follow for supplementary nerve blocks and the need for general anaesthesia, when compared to the method in supine position according to Bütter.

References:

A-436

Auxiliary brachial plexus block using ultrasound

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Background and Goal of Study: The success rate of axillary nerve block has become higher after an electrical stimulator has been introduced. However, the risk of the intravascular injection of local anesthetics or the risk of nerve injury has remained. In recent ultrasound (US) we can provide us the fine image of the axillary plexus (1). This study is, therefore, conducted to examine how useful is US to perform auxiliary nerve block.

Materials and Methods: After obtained informed consents, seventeen subjects (7 volunteers and 10 patients) were included in this study. Firstly, we examined how clearly each nerve in axillary sheath was identified using a linear transducer (5-11 MHz) connected with an ultrasound (Sonos 5500, Phillips Inc.). Secondary, we inserted the block needle (21G, 70 mm) into axillary sheath in the 10 patients (Pts) under US guidance. We decided the position of the needle tip as seeing US image and assessed how local anesthetic solution distributed in an axillary sheath during the injection. In 5 among 10 Pts, we used electrical nerve stimulator together with US to assessed weather the nerve image on US screen was the target nerve. The effect of block was evaluated with a loss of cold sense. The complexity assessed the next day of operation.

Results: US provided distinct images of axillary nerves in all subjects except one female. In 10 subjects (59%), three nerves (ulnar, median and radial nerves) could be identified. Two nerves could be seen in 5 subjects (27%). During the injection of local anesthetic, US showed that the solution was spreading in axillary sheath in all 10 Pts. In all of the 5 Pts with nerve stimulator together, the target muscle contraction could be elicited easily at the low stimulation current (0.3 to 0.7 mA). Anesthetic effects were confirmed in all patients. No intravascular injection of local anesthetic was occurred and no complication after block was observed.

Conclusions: Our results demonstrated that US could image the target nerve and the distribution of injected solution so clearly and easily. In conclusion, we believe that using guidance for auxiliary nerve block could increase the success rate and decrease the complications.

Reference:
1 Eur Radiol 12:44–55, 2002

A-437

Small dose levobupivacaine added to mepivacaine has greater analgesic effect than clonidine in axillary block

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Background and Goal of Study: Clonidine added to local anesthetics prolongs anesthesia and analgesia after axillary block. We hypothesized that a small dose of levobupivacaine added to mepivacaine may have similar effects.

Materials and Methods: Consentient ASA 1–2 patients undergoing hand surgery were randomized to axillary block, with electrotomistimulated needle and multiple injection technique, receiving: 1) 2% mepivacaine 5 mL for each terminal branch of the plexus (M); 2) as in group M plus 0.5% levobupivacaine 5 mL injected only near the branch mainly related to the surgical procedure (ML); 3) as in group M plus clonidine 150 mcg (MC). Patients unsuited for regional anesthesia, non compliant, undergoing procedures involving a field covered by > 1 branch or leading to negligible postoperative pain (e.g. carpel tunnel release) were excluded. All patients received paracetamol 1 g every 8 hours po. Ketoprofen was used as iv rescue analgesic. A blinded observer registered time of block onset and recovery, VAS pain scores at 1-2-4-6-8-12-24 hours, total consumption and time of first request of rescue analgesic. Data (mean ± SD) are compared using analysis of variance with Bonferroni correction. Time of first analgesic request is described by Kaplan Meier curves and compared by log-rank test.

Results and Discussions: 70 patients were studied (age: 18–70 years; M/F: 47/23). Anesthesia was adequate in all cases. Pain scores were lower only in group ML than in M (among groups, p = 0.01; M vs ML, p = 0.01; M vs MC, n.s.). Rescue analgesic consumption was similar. The proportion of rescue analgesic-free patients had a slower decrease in groups ML and MC than in M (analgesic-free at 24 hours 34% in group M, 73% in group ML, 55% in group MC; p < 0.001). Time of sensory and motor block was similar in groups M and ML. Recovery was significantly longer in MC (M: 212 ± 61; ML: 257 ± 100; MC: 298 ± 61 min, P = 0.02 vs MC).

Conclusion(s): Selective addition of levobupivacaine improves analgesia after axillary block with mepivacaine, without affecting onset and duration of sensory and motor block. Clonidine prolongs anesthesia but not analgesia.

Reference:
1 Sjogren et al. Anesth Analg 1996; 83: 1046–50

A-438

Anesthesia and postoperative analgesia in upper extremity and shoulder surgery

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Background and Goal of Study: Shoulder and upper extremity surgery often causes severe pain which requires high doses of opiates. Inadequate treatment of postoperative pain causes the patients to suffer pain and as a result their satisfaction decreases. In postoperative study we tried to determine the best method of anesthesia and postoperative analgesia (POA) in upper extremity surgery.

Materials and Methods: After obtaining approval of the local ethic commit- tee, 51 ASA I, II patients were randomly allocated to one of three groups. In Group G (n = 17); General anesthesia (GA) was applied to shoulder surgery and for POA intravenous (iv) PCA (patient controlled analgesia) with morphine was used. In Group IS (n = 17); Interscalene block (ISB) was performed with 0.6% 40 mL ropivacaine (R) to the consciousness patients, for POA IS catheter was used with PCA 0.2% R. Group ISG (n = 17); ISB was performed with 0.6% 40 mL R and IS catheter was placed. When surgery block was formed, GA was applied. For POA IS catheter was used with PCA 0.2% R, PCA in all the groups was set as both basal infusion and bolus. Pain was evaluated by VAS and VRS. For statistical analyses ANOVA, Kruskal- Wallis and Chi-square tests were used.

Results: Descriptive and postoperative hemodynamical data were similar in all group. Side effects such as Horner’s syndrome 34% (group IS: 23%, group ISG: 11%) and recurrent laryngeal nerve block 11.8% (group IS: 5.9%, group ISG: 5.9%) and agitation 5.9% (only group IS) nausea 84.2% in group G, 17.6% group IS and vomiting 58.8% in group G were observed, 64% of the patients with Group G, 10% of the patients with group IS, 5% of patients with Group ISG required additional analgesics and the postoperative VAS 24 h. Pain measurement by VAS and VRS clearly demonstrated the advantages of ISB with or without GA. The patients ISG and IS were more satisfied with their anesthesia and POA than the patients in G (78.12 ± 12.04, 92.65 ± 10.53 versus 78.24 ± 13.24, respectively, p < 0.05).
A-439

Posterior radial nerve blockade: an easy route for upper limb locoregional anaesthesia?
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Background and Goal of Study: We previously described a new route in surgical procedures of the upper limb (1). The aim of this study was to determine whether the posterior approach of the radial nerve (PARN) could provide both adequate conditions during the realisation of the block and excellent perioperative anaesthesia.

Materials and Methods: After institutional and patient approval, we prospectively studied 150 consecutive patients undergoing upper limb surgery. The radial nerve block was performed with a short bevel needle (Stimuplex®). Neuro stimulation (HNS), all patients were in the beach chair position, with the hand of the limb to block on the opposite shoulder. Function site is located 3 cm behind the humeral insertion of the deltoide muscle. The radial nerve is blocked in the triangle delimited by the Humerus, the Teres Major and the Long Head of the Triceps muscles. Only two neurostimulation responses are accepted to localise the radial nerve: wrist and finger extension or contraction of the humero-stylo-radial nerve. A contraction of the triceps muscle is not accepted because of the possibility of distal nerve stimulation. Distribution of anaesthesia in the nerve territory was assessed at 5, 10, 15, and 20 min by cold testing.

Results and Discussions: (The data is evaluated as average ± ecart type). Duration procedure (min): 1.43 ± 0.5; Time for complete sensitive block (min): 13 ± 3.53; minimal stimulation intensity (mA): 0.5; volume of ropivacaine 5 mg/mL: 12 mL. Supplementation was not needed by further LA in any case. Quality of anaesthesia was considered excellent in all cases, without complications.

Conclusion(s): PARN is a very efficient technique for radial nerve block.


A-440

Nerve stimulators: are they all the same?
Department of Anesthesi, CHU-Nancy, Nancy, France

Background and Goal of Study: Nerve stimulation is the gold standard method for confirmation of peripheral nerve location during regional anaesthesia. Nerve stimulators (NS) are essential for improving both the success rate and the risk-benefit ratio of regional anaesthesia (1). We investigated the safety and reliability of a series of NS available in France.

Materials and Methods: Eighteen different NS were subjected to a battery of tests (2) performed by two independent observers under standardized conditions using a digital oscilloscope (Tektronix TDS 3034) and a calibrated scanner at 4 levels from the elbow to the wrist and correlated to morphometric data. Nerve depths, dimensions, and the risk-benefit ratio of regional anaesthesia (1). We investigated the safety and reliability of a series of NS available in France.

Results and Discussions: (The data is evaluated as average ± ecart type). Duration procedure (min): 1.43 ± 0.5; Time for complete sensitive block (min): 13 ± 3.53; minimal stimulation intensity (mA): 0.5; volume of ropivacaine 5 mg/mL: 12 mL. Supplementation was not needed by further LA in any case. Quality of anaesthesia was considered excellent in all cases, without complications.

Conclusion(s): PARN is a very efficient technique for radial nerve block.

Conclusion: Lumbar plexus blockade provides better surgical field with minimum blood loss/comfortable recovery and reduced TAR and TBL. The similar prospective studies using continuous infusion with catheterisation may provide total analgesia for THR.

References:

A-443
Blood loss after total hip arthroplasty: a prospective audit comparing psoas compartment block to intrathecal morphine
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Background and Goal of Study: Psoas compartment block (PCB) reduces blood loss after total hip arthroplasty (THA) possibly as a result of superior postoperative analgesia compared to patient controlled morphine (PCM). Intrathecal morphine (ITM) provides similar postoperative analgesia as PCB (2).

Materials and Methods: As part of a prospective audit comparing two anaesthetic techniques for blood loss after primary THA, data from forty-eight patients were reviewed. Anaesthesia consisted of bupivacaine spinal anaesthesia with either ITM (Group M) or PCB (Group P) for postoperative analgesia. IRB approval was waived. The same surgeon performed all surgery. Pre- and postoperative haemoglobin (Hb) and haematocrit (HCT) were measured. Intraoperative blood loss measurement was standardized. Postoperative blood loss was recorded for 24 hours. Unpaired t test, Mann Whitney and Fisher’s exact tests were used for analysis as appropriate.

Results and Discussions: Data presented as Mean ± SD. The groups were similar except for intraoperative blood loss (Table). Blood transfusion was not required in either group.

<table>
<thead>
<tr>
<th></th>
<th>Group M (n= 19)</th>
<th>Group P (n= 21)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>70 ± 7</td>
<td>69 ± 9</td>
</tr>
<tr>
<td>Weight (kg)</td>
<td>85 ± 14</td>
<td>71 ± 9</td>
</tr>
<tr>
<td>Pre Hb (g/dl)</td>
<td>13.8 ± 1.1</td>
<td>13.7 ± 1.4</td>
</tr>
<tr>
<td>Post Hb (g/dl)</td>
<td>10.5 ± 0.8</td>
<td>10.3 ± 1.3</td>
</tr>
<tr>
<td>Pre HCT (l/l)</td>
<td>0.418 ± 0.027</td>
<td>0.412 ± 0.032</td>
</tr>
<tr>
<td>Post HCT (l/l)</td>
<td>0.318 ± 0.028</td>
<td>0.315 ± 0.035</td>
</tr>
<tr>
<td>Postop BL (ml)</td>
<td>771 ± 336</td>
<td>707 ± 353</td>
</tr>
</tbody>
</table>

Conclusions: PCB combined with spinal anaesthesia, for postoperative analgesia, does not reduce blood loss after TKA. This may be because as compared to patient controlled morphine (1), ITM provides equivalent postoperative analgesia as PCB (3).

References:

A-444
Ultrasound-guided approaches to the ilioinguinal and iliohypogastric nerve: accuracy of a highly selective new technique confirmed by anatomical dissection
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Background and Goal of Study: Ilioinguinal (IN) and iliohypogastric (IH) nerve blocks may be used to diagnose chronic neuropathic groin pain or to provide perioperative analgesia for hernia repair. The present study describes a new ultrasound-guided approach to these nerves and determines its accuracy using anatomical dissection control.

Material and Methods: Thirty seven ultrasound-guided approaches to the IN and IH nerve were performed in 11 embalmed cadavers. After injection of 0.1 ml of dye the cadavers were dissected to evaluate needle position and colouring of the targeted nerves.

Results: Thirty three of the 37 needle tips were located at the exact target point, in or directly at the IN or IH nerve. In all these cases the entire nerve was coloured by the dye. In two of the remaining four cases parts of the targeted nerves were coloured and in the two others the needle tip was found 5 mm away from the uncoloured nerve. This corresponds to a simulated block success rate of 95%. In contrast to the standard “blind” techniques of inguinal nerve blocks the nerves were targeted 5 cm cranial to the superior anterior iliac spine where the nerves could be visualised accurately by ultrasound. The median (range) diameters of the nerves measured by ultrasound were: IN: 3.0 (2.0–4.0) × 1.6 (0.7–2.1) mm. IH: 2.9 (1.8–3.5) × 1.6 (0.5–3.0) mm. The IN nerve was found at a median distance of 6.0 (4.0–11.0) mm medial to the iliococcygeus muscle and the median distance between the two nerves was 10.4 (7.0–14.3) mm.

Conclusions: The anatomical dissections confirmed that our new ultrasound-guided highly selective approach to the IN and IH nerve is accurate. Thus, ultrasound could become an attractive alternative to the “blind” standard techniques of IN and IH nerve block in pain medicine and anaesthetic practice.

A-445
The use of ultrasound to improve the accuracy of ilioinguinal and iliohypogastric nerve blocks
E. Dereeper, M. Sosnowski
Department of Anesthesiology, CHU Saint-Pierre, Brussels, Belgium

Background and Goal of Study: As some adverse events of the rachi-anesthesia could cause unplanned hospitalization of ambulatory patients, some authors suggest general anaesthesia for knee arthroscopy. Nevertheless, patients often request to watch the procedure. Since peripheral nerve blocks give excellent postoperative analgesia we have, here, evaluate the feasibility of an association of lumbar plexus block (LPB) and sciatic nerve block (SNB) for ambulatory arthroscopic meniscectomy (AAM) in our teaching hospital.

Materials and Methods: Forty-six ASA–1–2 consecutive patients (aged 20–83 years, M/F ratio 1:1) scheduled for AAM and demanding loco-regional anaesthesia were included in this study. Under light sedation, the patient laying on the side, a 100 mm isolated short-bevel needle (Stimuplex, B.Braun, Germany) and a neurostimulator were used to perform the SNB through the
parasacral approach and the LPB through the posterior approach. Fifteen ml (SNB) and 25 ml (LPB) of lidocaine 1.5% with epinephrine 1:200000 were injected. The nerve block was considered unsuccessful when a surgical block was not achieved within 20 min. Results and Discussions: In 39 patients (85%), the block was successful. For the 7 other patients, a general anesthesia had to be done. The reasons for failure were: accidental intravascular injection (1) and anxiety, pain felt under the tourniquet or at the medial side of the knee (5). In these last 5 patients the block was complete after surgery. Propacetamol and ketorolac were sufficient for every patient’s adequate postoperative analgesia. Success rate of trainees (71%) was lower than senior anesthesiologist (88%, p < 0.01). All the patients could leave the One Day Clinic on time. Conclusion(s): The success rate of SNB + LPB is acceptable and could be increased 1) if a longer onset time was accepted, 2) with appropriate training. The association of LPB and SNB is a suitable alternative for AAM in a teaching hospital.

References:
1 Capdevilla X. Anesth Analg 2002;94:1606–13
2 Mansour NY. Reg Anesth 1993;18:322–3

A-447

An anatomical study of the lumbar plexus and the psoas compartment in 95 cadavers
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Background and Goal of Study: Psoas compartment blocks for postoperative analgesia following total knee joint replacement may result in incomplete blocks even if accurate neurostimulation is applied. The underlying reasons have not clearly been identified. Anatomic dissections in small numbers of cadavers suggest intramuscular location within separated muscle folds. The purpose of the underlying study was to describe the relation of the lumbar plexus to the femoral nerve muscle complex at the L4 level. Results
Materials and Methods: In 95 formalin-fixed cadavers bilateral dissection of the lumbar region was performed by a ventral approach. The lumbar vertebrae and intervertebral discs of L5–L2 as well as the cranial border of the sacrum could be identified by dissection. The corresponding sites of the psoas muscles were marked in situ. Measurements were performed in situ on transversal and sagittal cross section dimension of both psoas muscles. The femoral (FEM), lateral cutaneus femoris (CFL) and obturator nerve (OBT) were marked. Then nerves were cut caudad to the muscles. Muscles were carefully separated from their insertion site at the spine and the fusion site with the iliacus muscle. The location of the corresponding nerves within or outside the muscles was studied with special regard to the L4 level. Results and Discussions: Complete measurements were performed in 95 cadavers (46 female, 49 male, age 81 ± 9 years, height 165 ± 9 cm, weight 58 ± 12 kg). Respective mean cross section dimension at the L4 level were 2.3 ± 0.5 mm (transversal) and 3.9 ± 0.8 mm (sagittal) for the left, and 2.4 ± 0.5 cm and 3.8 ± 0.7 for the right muscle. All diameters decreased with age. At the L4 level the FEM was located within the posterior part of the psoas muscle in 71.6% and the CFL in 57.4% of the cadavers. In 19 muscles the FEM consisted of 2 branches, whereof 6 had an extravascular course. The OBT never was located within the muscles and was covered by fat and connective tissue between vertebral bodies and psoas muscle. The CFL was divided in 2 portions, whereof 2 had an extravascular course.

Conclusion(s): The course of the three nerves varies considerably at the L4 level. Nerves dividing into branches and differences in location either within or outside of the muscle may explain incomplete block during psoas compartment block due to anatomical barriers inhibiting local anesthetic spread.

A-448

Efficiency of combined psoas compartment block and sciatic nerve block for total knee joint replacement
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Background and Goal of Study: Psoas compartment blocks (PCB) have been increasingly applied for intraoperative supplementation and postoperative pain relief following knee or hip surgery. In most cases PCB is performed in combination with general anaesthesia (GA). Therefore, little is reported concerning PCB and additional sciatic nerve block (SCB) for surgery. The purpose of the underlying study was to evaluate the efficiency and safety of PCB and SCB without additional GA for total knee joint replacement (TKJR) and to identify causes of block failure.

Materials and Methods: The records of 391 consecutive patients undergoing TKJR with tourniquet application in combined PCB and SCB were examined. All blocks were performed under the supervision of one of two anaesthetists, mostly by means of ultrasonic guidance with additional perineural nerve stimulation (PNS). There were two analgesic regimens used: ropivacaine 0.5% 100 mg and mepivacaine 1% 200 mg or ropivacaine 0.375% 75 mg and prilocaine 1% 200 mg by personal preference of the anaesthetist. If pain during surgery in the operated limb due to incision or from tourniquet occurred additional i.v. application of 1 µg/kg fentanyl was given. If pain persisted additional general anesthesia (GA) was performed. Need for additional GA or i.v. fentanyl was considered as block failure. Multivariate linear regression analysis was performed to identify causes of block failure.

Results and Discussions: Identification of the SCN was successful in all patients. In 2.5% of the patients identification of the lumbar plexus by PNS was not possible, hence alternative anesthetic procedure was chosen. 2.3% of patients received additional intravenous opioid analgesia for moderate pain relief. 11.7% had pain during incision or due to tourniquet application and were converted to GA. Multivariate regression analysis f(2) = 0.161 revealed the following risk factors for block failure: height (beta coefficient 0.245), duration of block performance (0.237), weight (0.184), history of rhematism (0.118). The local anesthetic used did not influence block success.

Conclusion(s): The combination of PCB and SCB allows TKJR without additional GA in 88.3% of cases. Technical difficulties during block performance in particular obesity as well as a history of rhematism may predict block failure.
Conclusions: The effects of sevoflurane on the antagonism effect and duration of neostigmine were less than enfurane, and there was no difference between sevoflurane and propofol except for the rocuronium infusion rate.

References:

A-451

Gender differences in the intubating conditions of rocuronium

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Background and Goals: There is increasing evidence for sex differences in the pharmacodynamics (PD) of anaesthetic drugs and neuromuscular blocking agents (NMBA), e.g. rocuronium (Roc; 1). The sensitivity of women to Roc was higher compared with men, requiring 30% less of the drug to achieve the same degree of neuromuscular block (2) and onset times were shorter. However, whether gender influences the intubating conditions (IntCond) after Roc and leads to an improvement of the IntCond in female patients (Pat) is unclear.

Materials and Methods: After Ethics Committee approval and informed consent, 80 female and 80 male Pat were randomised each in 2 groups (Gr) to receive Roc 0.6 mg/kg or succinylcholine (Sux; Control-Gr) 1.0 mg/kg. Induction: thiopentone (5 mg/kg), fentanyl (3 μg/kg), Roc (Roc-Gr) or Sux (Sux-Gr). 60s later, endotracheal intubation-int(ion) was performed. Time of int, difficulty of intubation (Cormack), and IntCond (3) were assessed. Stat: χ² test.

Results and Discussion: Men were significantly larger and heavier (p < 0.001) than women, but the body mass index was comparable (n.s.). Int time, and Cormack grades were comparable (n.s.). However, clinically acceptable (Clin accept; excellent and good) IntCond after Roc were significantly increased in the Female Gr compared to the Male Roc Gr: 80% vs. 47%, respectively; p < 0.05.

<table>
<thead>
<tr>
<th>Roc groups (n = 30)</th>
<th>Sux groups (n = 30)</th>
</tr>
</thead>
<tbody>
<tr>
<td>IntCond Female</td>
<td>IntCond Male</td>
</tr>
<tr>
<td>Male</td>
<td>Male</td>
</tr>
<tr>
<td>Excellent        6*</td>
<td>5*</td>
</tr>
<tr>
<td>Good             16†</td>
<td>9</td>
</tr>
<tr>
<td>Poor             6†</td>
<td>16</td>
</tr>
<tr>
<td>Clin accept 24*</td>
<td>14†</td>
</tr>
</tbody>
</table>

Values are numbers. *p < 0.05 vs. Male Roc Gr; †p < 0.05 vs. Female Sux Gr.

Conclusions: The IntCond after Roc were significantly better in women than in men, moreover it is an additional evidence for gender-related differences in PD. Thus, the incidence of clinically acceptable IntCond in the Female Gr was comparable with those in the Sux Gr (80%). The observed gender difference was related to Roc; the sex-related differences did not occur among the Control Gr.

References:
1 Acta Anaest Scand 2003; 47: 241–59
2 Anesth Analg 1997; 83: 667–71

A-453

Reversal by Org 25969 is not affected by sevoflurane compared with propofol

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Background and Goals: The modified γ-cycloexodrin, Org 25969, provides a novel approach to neuromuscular block reversal by quickly encapsulating stereois neuromuscular blocking agents and preventing their action. This phase II trial was designed to study efficacy and safety of Org 25969 when used with either sevoflurane or propofol maintenance anaesthesia.

Materials and Methods: After Ethics Committee approval, 42 patients aged 19–82 years with ASA Class 1–3 were enrolled. Each subject received a dose of 0.6 mg/kg rocuronium after propofol induction. For maintenance of anaesthesia, subjects were randomized to receive propofol (n = 21) or sevoflurane (n = 21). At reappearance of T2, 2.0 mg/kg of Org 25969 was administered as a single IV bolus. Anaesthesia was maintained until the end of surgery. Neumuscular function was monitored and recorded using accelerometry (TOF Watch SX). The primary endpoint was time from start of Org 25969 administration to recovery of T4/T1 to 0.9. A difference of <1 min in recovery time was considered not clinically relevant. Equivalence between the 2 groups was considered to be demonstrated if the 2-sided 95% CI for the difference between the 2 groups was within the range −1 min to +1 min.

Results and Discussion: Mean recovery time from Org 25969 administration to T4/T1 ratio to 0.9 was 1 min 50 sec with propofol and 1 min 48 sec with sevoflurane for maintenance of anaesthesia. The estimated mean time difference between the groups was −1 sec with 95% CI (−28 to 26 sec), well within the predefined range for equivalence. No recuarization was observed. There were 13 (31%) subjects with >1 AE; 4 in the propofol and 9 in the sevoflurane group; 6 AEs were considered treatment related. All 10 serious AEs (n = 8, QTc prolongation) were reported with sevoflurane, none were considered treatment-related. All AEs, except one, were mild to moderate, and there were no discontinuations or deaths.

Conclusions: After 2.0 mg/kg Org 25969 at reappearance of T2, recovery of the T4/T1 ratio to 0.9 was equivalent under propofol and sevoflurane maintenance anaesthesia. The safety profile in the former was somewhat more favourable.

A-454

Variability in the duration of action of Succinylcholine

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Background and Goal of Study: The short duration of action of Succinylcholine (SCh) is due to a rapid hydrolysis by pseudocholinesterase. It was questioned to be short enough to avoid severe hypoaxia in a situation where ventilation and intubation are impossible. Therefore, a dose reduction of SCh was suggested (1,2). The aim of this study was to determine the variability of duration of action of SCh in daily practice.
Materials and Methods: All patients with a clinical indication for the use of SCh were included. After induction of anesthesia, time from administration of SCh 1 mg/kg to return of neuromuscular function was recorded. Relaxation was measured by tactile assessment of muscle response following train-of-four stimulation of the ulnar nerve. Induction drugs, dosage and a short medical history including indication for use of SCh was noted. Two groups were compared using Student t-Test and multiple groups using ANOVA.

Results and Discussions: A total of 495 patients mean age 54 yr (15–93 yr) from both sexes (46% males), mean weight 75 kg (35–145 kg), were included. ASA status was I in 5%, II in 49%, III in 43% and IV in 3%. Indication for use of SCh was gastrointestinal regurgitation in 45%, fasting time ASA status was I in 5%, II in 49%, III in 43% and IV in 3%. Indication for use of SCh was gastrointestinal regurgitation in 45%, fasting time ASA status was I in 5%, II in 49%, III in 43% and IV in 3%. Indication for use of SCh was gastrointestinal regurgitation in 45%, fasting time ASA status was I in 5%, II in 49%, III in 43% and IV in 3%. Indication for use of SCh was gastrointestinal regurgitation in 45%, fasting time ASA status was I in 5%, II in 49%, III in 43% and IV in 3%. Indication for use of SCh was gastrointestinal regurgitation in 45%, fasting time ASA status was I in 5%, II in 49%, III in 43% and IV in 3%.

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Conclusions: Our results show a large variation in duration of action of SCh from 90 to 1800 seconds. ASA status and concomitant disease showed a significant influence on SCh duration of action. Such acquired deficiency of pseudocholinesterase activity, as well as genetic variations in this enzyme must be considered. Given the variability in pharmacokinetics of SCh a general dose reduction does not protect from over- or underdosage of this drug.

References:

2 Donati F. Anesthesiology 2003; 99(5): 1037–1038

A-455

Onset and duration of mivacurium-induced block in children with Charcot-Marie-Tooth disease


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Background and Goal of Study: The aim of this investigation was to compare the onset and the spontaneous recovery from mivacurium induced neuromuscular block (NMB) at the adductor pollicis (AP) and orbicularis oculi (OO) muscles in children with Charcot-Marie-Tooth (CMT) disease.

Materials and Methods: After obtaining approval of the local Ethic Committee the response to mivacurium was characterized in five children (ASA I, 6–11 yrs old) with CMT1. They were anaesthetised using propofol/fentanyl, the lungs ventilated with oxygen in air. After stable baseline signal a single bolus dose of 0.2 mg·kg⁻¹ mivacurium was given over 15 sec. Neuromuscular transmission was monitored by acceleromyography (TOF Watch SX) simultaneously at AP and OO muscles using train of four stimulation with 0.5 Hz. Lag time was 57 ± 13 sec and 34 ± 8 sec at AP and OO, respectively. Table 1 shows the time course of the response to mivacurium at AP and OO muscles. Overall, the documented response to mivacurium at AP is similar to data from children without neuromuscular disease (2). The recovery was faster at OO muscle. This is in accordance with data from adults (3). Remarkable is the recorded faster onset at AP compared to OO. This is in contrast to previous reports from patients without neuromuscular disease (3). Whether this finding indicates beginning involvement of hand muscles by CMT remains unclear.

Results and Discussions: Lag time was 57 ± 13 sec and 34 ± 8 sec at AP and OO, respectively. Table 1 shows the time course of the response to mivacurium at AP and OO muscles. Overall, the documented response to mivacurium at AP is similar to data from children without neuromuscular disease (2). The recovery was faster at OO muscle. This is in accordance with data from adults (3). Remarkable is the recorded faster onset at AP compared to OO. This is in contrast to previous reports from patients without neuromuscular disease (3). Whether this finding indicates beginning involvement of hand muscles by CMT remains unclear.

Conclusions: In this small series mivacurium effected a normal response in children with CMT type 1.

References:

1 Acta Anaesthesiol Scand 1996; 40: 59–74
2 Acta Anaesthesiol Scand 2002; 46: 512–18
3 Br J Anaesth 2000; 85: 856–60

A-456

Predictability of rocuronium-induced neuromuscular block

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Background and Goal: Following bolus dose of rocuronium, the average duration of neuromuscular block until 25% recovery (clinical duration) can be predicted by the dose-duration relationship. However, individual variations in drug responses make such prediction less accurate for the individual patient. In the present study, we investigated the use of both the dose and its onset time to predict the duration of rocuronium-induced neuromuscular block more precisely.

Materials and Methods: Following local ethics committee approval and obtaining informed consent, 210 patients scheduled for elective surgery under general anaesthesia with tracheal intubation were randomly allocated into seven groups with different rocuronium doses administered (0.30; 0.45; 0.60; 0.75; 0.90; 1.05; 1.20 mg·kg⁻¹, respectively). After setting up neuromuscular transmission monitoring (Datex-Ohmeda S/5 Anaesthesia Monitor with NMT module, ulnar nerve stimulation, TOF pattern, electromyographic evaluation of evoked response of the adductor pollicis muscle), tracheal intubation was performed after 80% depression of T₁. For each consecutive patient the onset time for 95% effect and the length of clinical duration were determined. Statistical analyses were performed by simple and multiple linear regressions (least-square method) to predict clinical duration for different values of the independent variables (dose and onset time). The squared correlation coefficient (r²) was used as the primary criterion for evaluation of the relevant model.

Results: The duration of action was better predicted by dose (r² = 0.64) than by onset time (r² = 0.54). The predictability was improved by a multiple regression model of these variables (r² = 0.71). The explanatory power was best when using the logarithm of clinical duration as the dependent variable (r² = 0.74).

Conclusion: The duration of rocuronium-induced neuromuscular block can be predicted more accurately by the combined use of dose and onset time than by dose (or onset time) alone.

Reference:


A-457

Neuromuscular block induced by rocuronium and reversed by the encapsulating agent Org 25969 can be re-established using the non-steroidal neuromuscular blockers succinylcholine and cis-astracurium

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Background and Goal of Study: Org 25969 is a reversal agent which acts by a new mechanism: encapsulation of steroidal neuromuscular blocking agents. After reversal of rocuronium-induced neuromuscular block by Org 25969, there will be a short period during which a second administration of rocuronium will have a variable effect. Aim of this study is to determine whether the non-steroidal neuromuscular blocking agents succinylcholine and cis-astracurium can be used in these circumstances, since these to agents are not encapsulated by Org 25969.

Materials and Methods: Male guinea pigs were deeply anaesthetised with urethane and artificially ventilated. Single twitch M. gastrocnemius contractions were induced by electrical stimulation of the sciatic nerve. Catheters were placed in the jugular vein and carotid artery for intravenous drug administration and blood pressure measurements.

Results and Discussions: Bolus administration of 429 ng·kg⁻¹ rocuronium resulted in complete neuromuscular block, which was completely reversed with 500 nmol/kg Org 25969. Three minutes after complete reversal, the animals received 650 nmol/kg succinylcholine (n = 4), 180 nmol/kg cis-astracurium (n = 4) or 429 nmol/kg rocuronium (n = 4). Succinylcholine caused complete block with a slightly delayed onset (ref 1) (2.0 ± 0.2 min vs. 1.2 ± 0.5 min in untreated group; mean ± SEM) and a normal speed of recovery.

Conclusions: Cis-astracurium caused complete block with normal speed of onset (2.0 ± 0.5 vs 8.3 ± 3.5 min in untreated group) and normal speed of recovery. Rocuronium caused variable degrees of neuromuscular block, ranging from no block to 97% block. However, when rocuronium was administered 30 min after administration of Org 25969, complete block could be induced in all animals.

Reference:

A-458

Reversal of high-dose rocuronium with Org 25969

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Background and Goals: Org 25969, a cyclodextrin derivative, is an effective agent for reversing rocuronium (ROC) induced neuromuscular block in animals and humans [1,2,3]. The objective of this study was to evaluate the dose response relationship of Org 25969 given for reversal of high-dose ROC (1.0 mg/kg) induced neuromuscular block.

Materials and Methods: Following ethics committee approval, 87 ASA 1–3 patients (aged 18–80 yrs) consented to participate in this phase II multicentre trial. Neuromuscular block was measured accelero-myographically (TOF-Watch® SX). T4/T1 ratio values were used for analysis. Each patient received 1.0 mg/kg ROC for intubation, followed 3 (n = 59) or 15 (n = 27) min later by placebo or 2.0, 4.0, 8.0, 12.0 or 16.0 mg/kg Org 25969. The efficacy and safety (i.e. adverse events, vital signs, and EKG) of Org 25969 were studied. The primary end-point was the time from administration of Org 25969 until recovery of the T4/T1 ratio to 0.9.

Results: The table shows the recovery times (min/sec) of the T4/T1 ratio to 0.9 following different doses of Org 25969, given in mean (SD).

<table>
<thead>
<tr>
<th>Dose Org</th>
<th>3 min after ROC</th>
<th>15 min after ROC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placebo</td>
<td>108 ± 26 (31-10)</td>
<td>127 ± 22 (92-46)</td>
</tr>
<tr>
<td>2.0 mg/kg</td>
<td>44 ± 44 (22-11)</td>
<td>82 ± 32 (1-07)</td>
</tr>
<tr>
<td>4.0 mg/kg</td>
<td>6 ± 56 (0-52)</td>
<td>5 ± 28 (3-08)</td>
</tr>
<tr>
<td>6.0 mg/kg</td>
<td>2 ± 24 (1-10)</td>
<td>1 ± 51 (0-33)</td>
</tr>
<tr>
<td>12.0 mg/kg</td>
<td>2 ± 25 (0-07)</td>
<td>1 ± 47 (0-50)</td>
</tr>
<tr>
<td>16.0 mg/kg</td>
<td>1 ± 46 (0-08)</td>
<td>0 ± 56 (0-08)</td>
</tr>
</tbody>
</table>

In total six adverse events were reported. None were considered related to Org 25969. No recurarization was observed.

Conclusion: Org 25969 is well tolerated and has a good safety profile. Profound neuromuscular block after high-dose ROC (1.0 mg/kg) was on average reversed within 2.5 min for doses of 8.0 mg/kg Org 25969 or higher. A clear dose-response relationship in the time to recovery of the T4/T1 ratio to 0.9 was determined for both time points of administration.

References:

A-459

Model-independent calculation of $k_0$ values

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Background and Goal of the Study: The $k_0$ value is the first order rate constant determining the efflux from the effect compartment. Normally, a fractional sigmoid $E_{max}$ model is used for estimating individual $k_0$ values. Up to now no model-independent method was available to estimate $k_0$ for increasing and decreasing anaesthetic drug concentrations. In this study we calculated model-independent $k_0$ values for isoflurane (Iso), sevoflurane (Sevo) and desflurane (Des). The Bispectral index (BIS XP; Aspect, USA) and the Narcotrend index (Monitor Technik, Germany, version 4.0) were used as electroencephalographic measures of the drug effect.

Methods: With IRB approval and written informed consent we investigated 45 patients (15 each group) scheduled for a radical prostatectomy. After lumbar epidural catheterisation, patients received remifentanil and propofol solely for induction of anaesthesia. Thereafter, epidural analgesia was initiated, and Iso-, Sevo- or Des-flurane were added to maintain unconsciousness. At least 45 min later, end-tidal concentrations were varied between 0.5 and 2 MAC. We estimated an individual $k_0$ value for each patient using prediction probability ($P_0$). The computations were performed on a spreadsheet using the Excel 2000 software program (Microsoft, USA), the $k_0$ value was optimized to maximize the $P_0$ value to predict EEG indices versus effect site concentration data. Mean $P_0$ indicates statistical significance.

Results:

<table>
<thead>
<tr>
<th>Bistropical Index</th>
<th>Narcotrend Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>$k_0$</td>
<td>$P_0$</td>
</tr>
<tr>
<td>Iso 0.19 ± 0.09</td>
<td>0.69 ± 0.09</td>
</tr>
<tr>
<td>Sevo 0.23 ± 0.23</td>
<td>0.81 ± 0.04</td>
</tr>
<tr>
<td>Des 0.33 ± 0.22*</td>
<td>0.73 ± 0.05*</td>
</tr>
</tbody>
</table>

$a$Narcotrend vs BIS, $b$Sevoflurane vs Isoflurane, $c$ Desflurane vs Sevoflurane

Conclusion: The $k_0$ value of Des is significantly higher than the $k_0$ values of Iso or Sevo. Prediction probability depends on the respective volatile anaesthetic.

A-460

Evaluation of predicted effect-site propofol concentration with conventional PK model during induction of anaesthesia

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Background and Goal of Study: The predicted concentrations of propofol at the time of loss of consciousness are used for investigation of concentration-effect relationship of propofol. However, a three-compartment pharmacokinetic model has limitations for describing initial distribution of propofol (1, 2). The goal of this study is to evaluate the predicted effect-site concentration of propofol during the induction of anaesthesia.

Materials and Methods: Twenty patients were randomly allocated to two groups according to the propofol target concentrations (10 patients each). They were premedicated with midazolam 0.02–0.05 mg kg$^{-1}$ IM 30 min before the induction of anaesthesia. After the dose of fentanyl 1–2 μg kg$^{-1}$, propofol TCI was commenced at a target plasma concentration of 3 μg ml$^{-1}$ (L group) or 6 μg ml$^{-1}$ (H group) using a target-controlled infuson pump (Diprifuor™, AstraZeneca). The effect-site concentration (Ce) of propofol at the time of loss of response to verbal command (LOR) and the time from the start of propofol infusion to LOR (Time to LOR) were recorded. The two-sample unpaired t-test and chi-squared test were used for comparing continuous and categorical variables, respectively. P value less than 0.05 was considered significant.

Results: The patient demographic data, Ce at LOR, and Time to LOR (Mean ± SD) are shown in the table.

<table>
<thead>
<tr>
<th>Group</th>
<th>LOR (min)</th>
<th>Time to LOR (min)</th>
</tr>
</thead>
<tbody>
<tr>
<td>L group</td>
<td>H group</td>
<td>P value</td>
</tr>
<tr>
<td>Age (yrs)</td>
<td>53.0 ± 19.3</td>
<td>56.0 ± 18.8</td>
</tr>
<tr>
<td>Sex (male:female)</td>
<td>3:7</td>
<td>3:7</td>
</tr>
<tr>
<td>Weight (kg)</td>
<td>56.3 ± 10.9</td>
<td>53.8 ± 8.5</td>
</tr>
<tr>
<td>Height (cm)</td>
<td>157.6 ± 10.6</td>
<td>168.1 ± 5.9</td>
</tr>
<tr>
<td>Ce at LOR (μg ml$^{-1}$)</td>
<td>0.77 ± 0.18</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Time to LOR (sec)</td>
<td>49.2 ± 8.9</td>
<td>43.5 ± 7.8</td>
</tr>
</tbody>
</table>

Conclusion: It was suggested that the value of predicted effect-site concentration was inappropriate during the induction of anaesthesia, because there was a significant difference in Ce at LOR between the groups.

References:

A-461

Pharmacokinetics of isoflurane: elimination from body and brain


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Background and Goals: Our previous study has demonstrated the dynamic changes of inspiratory (CI), end-tidal (CE), arterial (A), pulmonary arterial (PA) and jugular bulb (J) isoflurane (iso) concentrations immediately after administering iso, but no study available shows the above changes after an iso vaporizer was shut down during emergence from anaesthesia in humans. The study was designed to look into iso elimination from the body in surgical patients.

Materials and Methods: Sixteen patients (aged 48 to 78), undergoing coronary arterial bypass grafting surgery were enrolled in this study. At least 30 min before skin closure, 2% iso in 6 I of O$_2$ was given into an anaesthetic circuit under controlled ventilation. An iso vaporizer was shut down when skin was closed. 20 min before and 40 min after the operation was ended, blood was withdrawn from a radial artery, pulmonary artery, jugular bulb via 3 different catheters and was analyzed to determine iso concentration by a head-space gas chromatograph. Additionally, Cliso and CEiso were also measured with a multi-gas analyzer.

Results: The CEiso was decreased rapidly during washout time compared to Also, Jiso and PAiso. At the 30th and 40th min washout, CEiso/PAiso were 68% and 57%, respectively. There were no significant differences among Also, Jiso and PAiso, but the absolute value of PAiso was the lowest during the 10th min to the 40th min washout time.

Conclusions: The study demonstrated the concentration-time profiles of Cliso, CEiso, Also, Jiso and PAiso before and after an iso vaporizer was closed.
From these profiles, we found that CEiso is decreased more rapidly than Aiso, Jiso and Piso and there is a relatively large gap existed between CEiso and Aiso, Jiso or Piso. Thus, it should be taken account into if CEiso is considered to be an indicator of emergence from anaesthesia.

**A-463**

Systematic curarisation is not essential during retroperitoneoscopy in uroscopy

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**Background and Goal of Study:** Systematic curarisation is recommended during laparoscopy to facilitate abdominal dissection and ensure low respiratory pressure. This study aim to evaluate benefit of curarisation in laparoscopic (Lp) and retroperitoneoscopic (Rp) uroscopy.

**Materials and Methods:** We planned to study 2 groups of 20 patients operated by Rp or Lp. Anaesthesia and intubation were achieved with midazolam, propofol, suftentanil and maintained by isoflurane (0.8 MAC), and suftentanil (0.3–0.4 µg/kg/hour). Atracurium (0.5 mg/kg) was only injected 30 min after insufflation. Ventilation was controlled (O2:N2O = 5:50) with a tidal volume (VT) of 8 ml/kg and a respiratory rate adapted to obtain PetCO2 between 30–35 mmHg before insufflation. Peak, mean and plateau inspiratory pressures, PetCO2, mean arterial pressure, and train of four were recorded before insufflation and every 15 min after. The static compliance (Cst) and CO2 production (VCO2) were calculated:

\[
\text{Cst} = \frac{\text{expiratory VT}}{\text{Inspiratory Plateau P}}
\]

\[
\text{VCO2} = \frac{\text{PetCO2} \times \text{Vm}}{(\text{Pb}-\text{PH2O}) \times \text{mmHg} \times \text{Weight (kg)}}
\]

**Results and Discussions:** Rp group was interrupted after 8 patients because of the difficulties expressed by the surgeon in realisation of pneumoperitoneum for 2/8 patients. In Rp group, only two patients out of 20 required curarisation before insufflation to facilitate space dissection. For the other 18 patients, after curarisation, the compliance remained unchanged and the VCO2 continued to increase.

**Conclusion:** Insufflation and space dissection were satisfactorily performed in 90% of the patients operated by Rp and without any difficulty in ventilation. Curarisation at the 30th minute did not improve Cst. Systematic curarisation is not essential during Rp in urologic surgery.

**A-464**

Concentration-dependent instability of propofol in whole human blood


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**Background and Goal of Study:** Propofol is strongly associated with both plasma proteins and blood cell constituents, therefore quantification in whole blood is recommended. We developed a novel solid phase extraction procedure for extracting propofol from whole blood prior to analysis by high performance liquid chromatography with fluorescence detection. The assay requires only 100 µL of whole blood and hence is suitable for the determination of propofol concentrations in vulnerable patient groups. The assay was used to investigate propofol stability in whole blood during refrigerated storage.

**Materials and Methods:** Whole human blood was spiked to six clinically relevant concentrations (ranging from 0.1 to 8 µg/mL) and stored in a refrigerater (4–5°C). Propofol quantification was performed immediately prior to storage. Quantification was repeated after one day of storage, at weekly intervals for up to six weeks of storage, and after 8 and 12 weeks of storage.

**Results and Discussion:** At concentrations of 2 µg/mL and below, the mean ratio of propofol loss was less than 1 ng per day and the slope of the regression lines were not significantly different from zero (p > 0.4). However, propofol loss from high concentration samples was significant (p < 0.01). The respective mean rates of propofol loss at 4 and 8 µg/mL were 6 and 9 ng per day respectively (95% confidence intervals: 3 to 10, and 3 to 14).

**Conclusion:** The stability of propofol in whole blood during refrigerated storage was found to be significantly dependent on the propofol concentration. The data obtained in this study suggest that propofol quantification should be performed as soon as possible after sample collection, and for samples likely to contain high concentrations of propofol (>2 µg/mL) certainly within six weeks.


**A-465**

Comparison of two propofol doses for intubation without myorelaxant using remifentanil

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**Introduction:** Orotracheal intubation without myorelaxant could be attractive especially in the event of myorelaxant allergy. However an incomplete opening of the vocal cords or the occurring of a motor response can increase the risk of laryngeal trauma. Our objective was to compare intubation conditions depending on the initial dose of propofol, associated with remifentanil.

**Material and Methods:** This prospective study was carried out on 80 patients ASA I or II allocated randomly in two groups. The initial dose of propofol was 2.5 mg/kg (P2.5 group) or 3 mg/kg (P3 group) infused during one minute. Remifentanil was associated at 1 mcg/kg during 30 sec then 0.5 mcg kg \(^{-1}\) min \(^{-1}\) (2 mcg/kg as total dose before intubation). The patients were intubated 2 min after the end of propofol administration. In case of incorrect conditions for intubation, the patients received one or several additional injections of propofol (0.5 mg/kg). The intubation conditions were evaluated using Scheller’s criteria (1) (mask ventilation, inferior jaw mobility, glottis exposure, vocal cords opening, and motor response at intubation time).

**Results:** All patients were intubated without myorelaxant. There was no significant difference between the two groups in terms of mask ventilation, inferior jaw mobility, glottis exposure. 11 patients in the P2.5 group (27.5%) received one or several additional injections of propofol whereas none in the P3 group (p = 0.0003). Despite this dose increase, 22 patients of P2.5 group (55%) had motor response whereas only 5 (20%) in the P3 group (p = 0.002).

**Conclusion:** The association propofol-remifentanil allows intubation without myorelaxant in good conditions. However, an initial dose of 3 mg/kg of propofol was necessary in order to limit the risk of motor response and an eventual laryngeal trauma. These results suggest that the use of a single initial bolus infusion of 3 mg/kg of propofol is more efficient than 2.5 mg/kg with eventual additional injections for intubation without myorelaxant.


**A-467**

Onset of neuromuscular block and intubating conditions: one minute after administration of rocuronium bromide in different regimens. The value of the priming technique

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**Background and Goal of Study:** The onset time of an intubating dose of Rocuronium is faster than that of all available nondepolarizing neuromuscular blocking agents, this being close related with the rate of development of adequate intubating conditions. Various studies have shown that administration of ‘priming’ doses of Rocuronium is not necessary for the induction of good to excellent intubating conditions at 60 sec., nor not it decreased the onset time.

The goal of this study was to compare intubating conditions that are achieved using priming technique and different doses of rocuronium.

**Materials and Methods:** The study was prospective (1.05.2004 – 1.12.2004) and included 167 patients with ASA I–II, scheduled for abdominal surgery under general balanced anesthesia. After induction of anesthesia with Fentanyl (3 µg/kg) and Propofol (1.5–2 mg/kg) three groups of patients received 0.6 mg/kg of rocuronium (group 1, n = 67), 0.8 mg/kg of rocuronium with a priming dose (group 2, n = 57), and 0.9 mg/kg (group 3, n = 49). Intubating conditions at 60 sec, after the administration of the bolus of rocuronium were assessed by a clinical intubating score – excellent (1) to impossible (4). Neuromuscular function was evaluated using the TOF values achieved using the TOF values measured at 45 sec. 60 sec. and 90 sec. after administration of rocuronium.
Intubating scores of the three groups were compared using nonparametrical statistical tests (Mann-Whitney).

**Results and Discussions:** All three doses induced good to excellent clinical conditions of intubation at 60 sec. after administration of rocuronium: (Group 1 mean = 2.26, SD = 0.95; group 2 mean = 1.74, SD = 0.81; and group 3 mean = 1.69, SD = 0.99) with significantly better scores in groups 2 and 3 versus group 1 (p = 0.022 respectively p < 0.001). The TOF scores measured in group 2 were significantly smaller than those in group 1 at 45 and 60 sec. (p < 0.001, respectively p = 0.003) and were similar with group 3 at 60 sec. (p = 0.757).

**Conclusion(s):** Standard doses (0.6 mg/kgc) of rocuronium given with priming technique can achieve within 1 min. intubating conditions as good as those induced with the high dose (0.9 mg/kgc), and still avoiding the longer clinical duration of this latter.

### A-468

**Rocuronium valuation as an indicator of the hepatic function during the vascular reperfusion of the hepatic graft: effect of changing the order of the vascular clamp release**

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**Background and Goal of Study:** Effect of rocuronium is directly related to the plasmatic concentration that depends on the bleeding, blood volume changes and hepatic metabolism. Several studies have suggested it might be used to assess liver function during liver transplantation. The goal of our study was to demonstrate the variations in rocuronium pharmacokinetics and pharmacodynamics when the order of the vascular clamp release at reperfusion of the hepatic graft was changed.

**Materials and Methods:** After excluding patients with neuromuscular diseases, acute hepatic failure, renal failure and amyloidosis, thirty patients were randomised in two groups. One group (n = 15) where portal vein was released first and the other (n = 15) where hepatic artery is released first. Anaesthesia was induced with an intravenous bolus of rocuronium of 1 mg/kg of ideal weight. After 15 min, a rocuronium infusion was initiated at 0.3 mg/kg/h. Changes of >0.05 mg/kg/h were done to maintain response for the first stimulus of the train of four between 10 and 25% of the control. We measured rocuronium plasmatic concentration at induction, at the hepatic phase, after the first and second reperusions, 60 min. after and at the end of surgery.

**Results and Discussions:** There were no statistical differences in the patients' demographic characteristics neither in the degree of hepatic failure. There were no differences between groups in rocuronium needs in the phases of the proceeding. Rocuronium plasmatic concentrations of eleven patients are shown in the table (mean ± SD; p < 0.05, non-parametric tests).

<table>
<thead>
<tr>
<th>Plasmatic Values</th>
<th>Artery 1st n = 5</th>
<th>Portal 1st n = 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>After induction (ng/ml)</td>
<td>2041 ± 394</td>
<td>2921 ± 957</td>
</tr>
<tr>
<td>Anhepatic phase</td>
<td>2373 ± 425</td>
<td>2303 ± 523</td>
</tr>
<tr>
<td>After 1st reperfusion</td>
<td>2053 ± 631</td>
<td>1897 ± 843*</td>
</tr>
<tr>
<td>After 2nd reperfusion</td>
<td>1670 ± 635</td>
<td>1820 ± 494</td>
</tr>
<tr>
<td>60 min. later</td>
<td>1318 ± 866</td>
<td>1735 ± 911</td>
</tr>
<tr>
<td>End of surgery</td>
<td>995 ± 375</td>
<td>918 ± 360</td>
</tr>
</tbody>
</table>

**Conclusion(s):** During portal reperfusion, sudden blood volume variation did affect rocuronium plasmatic concentrations in both groups. At the end of the procedure rocuronium plasmatic concentrations might be related to graft metabolism.

### A-469

**Renal effects of magnesium sulphate after suprareclic aortic unclamping in experimental dogs**

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**Background and Goals:** Intravascular administration of magnesium (Mg) causes vasodilation (1) and increases renal blood flow (2). We hypothesize that Mg might effectively augment renal perfusion, and prevent renal dysfunction following cross clamping of the aorta.

**Materials and Methods:** We compared 14 dogs, 7 control group (C) and 7 Mg group. In the Mg group, 30 mg/kg MgSO4 was injected over 3 minutes as a bolus immediately prior to unclamping the suprareclic aorta and thereafter as an infusion (10 mg/kg/h). Renal vascular resistance (RVR), renal cortical blood flow (RCBF), renal oxygen delivery (R-DO2), and renal function were measured at 1 and 6 hours after aortic unclamping.

**Results:** Data (mean ± SD) are shown in the table:

<table>
<thead>
<tr>
<th>RVR (dyn/s/cm²)</th>
<th>Baseline</th>
<th>Unclamp-1</th>
<th>Unclamp-6</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>59.6 ± 14.6</td>
<td>110.9 ± 48.5*</td>
<td>92.7 ± 29.2*</td>
</tr>
<tr>
<td>Mg</td>
<td>67.3 ± 24.5</td>
<td>72.9 ± 34.6</td>
<td>70.9 ± 10.8</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RCBF (ml/min/100 g)</th>
<th>Baseline</th>
<th>Unclamp-1</th>
<th>Unclamp-6</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>57.0 ± 11.9</td>
<td>44.7 ± 22.1</td>
<td>40.0 ± 11.3*</td>
</tr>
<tr>
<td>Mg</td>
<td>66.3 ± 24.3</td>
<td>57.3 ± 27.1</td>
<td>90.4 ± 43.6†</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>R-DO2 (ml/min)</th>
<th>Baseline</th>
<th>Unclamp-1</th>
<th>Unclamp-6</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>23.2 ± 4.4</td>
<td>14.0 ± 2.6*</td>
<td>11.8 ± 3.4*</td>
</tr>
<tr>
<td>Mg</td>
<td>25.1 ± 7.9</td>
<td>18.6 ± 4.3*</td>
<td>17.6 ± 3.6†</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Renin activity (ng/ml)</th>
<th>Baseline</th>
<th>Unclamp-1</th>
<th>Unclamp-6</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>7.46 ± 1.44</td>
<td>–</td>
<td>10.24 ± 4.06</td>
</tr>
<tr>
<td>Mg</td>
<td>7.96 ± 1.11</td>
<td>–</td>
<td>10.64 ± 4.95</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C-tent-C (mg/l)</th>
<th>Baseline</th>
<th>Unclamp-1</th>
<th>Unclamp-6</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>0.78 ± 0.07</td>
<td>–</td>
<td>0.84 ± 0.24</td>
</tr>
<tr>
<td>Mg</td>
<td>0.84 ± 0.21</td>
<td>–</td>
<td>0.92 ± 0.24</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C-react-C (pg/ml)</th>
<th>Baseline</th>
<th>Unclamp-1</th>
<th>Unclamp-6</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>0.13 ± 0.01</td>
<td>–</td>
<td>0.12 ± 0.03</td>
</tr>
<tr>
<td>Mg</td>
<td>0.13 ± 0.04</td>
<td>–</td>
<td>0.10 ± 0.02</td>
</tr>
</tbody>
</table>

*p < 0.05 vs baseline; †p < 0.05 vs group C.

**Conclusions:** Mg infusion attenuates the increase in RVR and the decrease in R-DO2, and improves RCBF after aortic unclamp in dogs. However, despite these beneficial effects, we did not observe any improvement in renal function when Mg was administered after suprareclic aortic unclamp.

**References:**


### A-471

**Xenon acts by inhibition of glutamatergic neurotransmission in Caenorhabditis elegans**

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**Background and Goal of Study:** The mechanism of action of the anesthetic gas xenon is ill-defined. In vitro electrophysiological studies implicate antagonism of several types of postsynaptic ion channels, the most prominent of which is the NMDA subtype glutamate receptor (1), as potential mechanisms of action. We have previously provided genetic evidence that nitrous oxide (N2O) and anesthetic gas similar to xenon, acts through inhibition of the NMDA receptor in vivo (2). The goal of this study was to determine the behavioral effects of xenon in the nematode C. elegans and furthermore to test the hypothesis that the main mechanism of action of xenon is through inhibition of NMDA subtype glutamatergic neurotransmission.

**Materials and Methods:** Well-fed one-day post-L4 adult C. elegans animals were transferred by platinum wire to agar pads with no bacteria; the pads were placed into glass chambers containing either a 75%-25% xenon:O2 mixture or air. After a 10-min incubation period, locomotion was scored over a seven-minute period. At least 10 animals were scored for each data point or strain.

**Results and Discussions:** Xenon produced behavioral effects similar to those seen with N2O. Like N2O but unlike volatile anesthetics, xenon did not affect gross locomotion but markedly changed the character of movement. Xenon greatly reduced the frequency of reversals of direction of movement in wild-type worms, an unusual behavioral effect otherwise only seen in worms with reduced glutamatergic neurotransmission. The E100 for xenon was 19% ± 3.9%. Surprisingly, a mutant lacking the NMDA receptor NMR-1 was normally sensitive to xenon whereas being resistant to N2O. However, a non-NMDA receptor null mutant glr-1(ky176), which is sensitive to N2O, was not affected by and thus resistant to xenon.

**Conclusion(s):** Our findings show that the main mechanism of action of xenon in C. elegans is by inhibiting glutamatergic neurotransmission. The sensitivity of the NMDA receptor null mutant to xenon argues that, unlike N2O, xenon does not act through the NMDA receptor; rather a non-NMDA receptor is more central to xenon’s action in C. elegans.

**References:**


### A-472

**Cyclooxygenase-2 expression in opioid-tolerant mice during CFA-induced monoarthrititis**

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**Background and Goal of Study:** Opioids are used in the management of chronic inflammatory pain in humans, but the development of tolerance
(TOL) is poorly characterised. Prostaglandins have been reported to play a role in the development of TOL [1]. Our aim was to determine COX-2 expression in mice with chronic mononuclear mononucleosis chronically exposed to opioids.

Materials and Methods: After approval by the Animal’s Ethics’s Committee, mononuclear was induced by the subplantar injection of CFA. Tolerance was obtained after the subcutaneous implantation of a 75mg morphine pellet, 4 days after CFA. COX-2 expression was assessed by western blot in the spinal cord (SC) and the infiltrated tissue (paw) from 6 hours to 7 days after CFA, and in TOL and CFA + TOL animals at 7 days. ANOVA was used for the statistical analysis.

Results and Discussion: In the paw, COX-2 expression was increased 15-times 24 h after inflammation (p < 0.001) but no changes were observed in TOL mice. In the SC, COX-2 expression increased 2-fold 24 h after inflammation (p < 0.001) and returned to basal values at 48 h. In the same tissue, TOL significantly increased COX-2 expression (p < 0.002) in controls (7 days), but not in CFA-tolerant mice. Results are expressed as mean values and vertical bars indicate the standard error.

Conclusions: Our results show that chronic exposure to morphine significantly enhances COX-2 expression in the spinal cord, but not in peripheral tissues (paw).

A-473

Xenon induced preconditioning involves increased HSP27 translocation and actin-HSP27 colocalisation

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Background and Goal: Xenon induces myocardial protection by pharmacological preconditioning (PC) in vivo. We demonstrated that this mechanism involves increased phosphorylation of MAPK-activated protein kinase-2 (MAPKAPK-2) and HSP27 downstream of PKC-ε p38 MAPK. The present study elucidated whether xenon induces HSP27 translocation to the particulate fraction and which protein-protein interactions between HSP27 and the actin cytoskeleton are initiated by Xe-PC.

Materials and Methods: Anaesthetised rats inhale xenon (Xe-PC, n = 6) during three 5-min periods interspersed with two 5-min and one final 10-min washout period. Control rats (n = 6) remained untreated for 45 min. Additional rats were pretreated with the p38 MAPK inhibitor SB203580 (1 mg/kg i.v.) with and without anaesthetic preconditioning (each, n = 6). Hearts were excised for immunohistochemistry of F-actin stress fibres and tissue fractionation followed by Western blot of HSP27, HSP27 and actin colocalisation was investigated by co-immunoprecipitation. Statistical analysis: One-way ANOVA followed by Bonferroni’s correction for multiple comparisons. Data are expressed as arbitrary units of average light intensity (AVI, western blot), means ± SEM.

Results: Xenon increased the amount of HSP27 in the particulate fraction (2.3 ± 0.4 vs. 0.8 ± 0.2 in controls, p < 0.05). This translocation to the particulate fraction was blocked by the p38 MAPK inhibitor SB203580 (0.7 ± 0.2, p < 0.05 vs. Xe-PC), SB203580 alone had no effect on HSP27 translocation (0.9 ± 0.4, p > 0.05 vs. controls). Xe-PC increased F-actin polymerisation. Actin and HSP27 were co-localised after Xe-PC.

Conclusion: Xe-PC induces the translocation of HSP27 downstream of p38 MAPK. Moreover, actin and HSP27 are co-localised after Xe-PC, linking the cardioprotection by Xe-PC to the actin cytoskeleton.

References:
1 Weber et al.: Br J Pharmacol 2004 Dec 6; [Epub ahead of print]
2 Weber et al.: Anesthesiology 2004; 101: A642

Acknowledgements: Supported by the Else Kröner-Fresenius-Stiftung, Bad Homburg, Germany and the European Society of Anaesthesiologists. O. Toma was supported by the Catholic Academic Exchange Service.

A-474

Beta-3-adrenoceptors are involved in beta-adrenoceptor signalling pathway dysfunction in diabetic cardiomyopathy

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Background: Positive inotropic response to β-adrenoceptor stimulation is markedly altered in diabetic myocardium (1). Although down-regulation of β-adrenoceptors and up-regulation of β3-adrenoceptors have been observed in diabetic cardiomyopathy (2), the effect of β3-adrenoceptors stimulation remains unknown in diabetic cardiomyopathy.

Methods: Effect of β3-adrenoceptor inhibition (directly by S-cyanopindolol or indirectly by L-NNAME) on the inotropic responses of β3-adrenoceptor stimulations (isoproterenol: 10-6 to 10-4 M) were studied, in vitro (Kreb-Henselet solution, 29°C, pH 7.40, Ca 1+ 0.5 mmol, stimulation of 12/min), in papillary muscles of diabetic rats (four weeks after intravenous injection of streptozotocin). Maximum isometric active force normalized per cross-sectional area (AF) was measured and comparison between groups was performed using ANOVA.

A-475

Changes in the viscosity of simple artificial phospholipid membrane by volatile anesthetics

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Background and Goal of Study: The mechanism of volatile anesthetics has been still controversial. In this study, we evaluated the direct effect of sevoflurane (sevo) and isoflurane (iso) on the simple artificial phospholipid membrane. For this, we measured the changes in the phospholipid membrane viscosity under various anesthetic concentrations by using fluorescence depolarization method.

Materials and Methods: The simple artificial phospholipid membrane was prepared from DPPC (Dipalmityl-L-phosphatidylcholine). We set the volatile anesthetics solution at 0.1, 0.2, 0.5, 1.2, 4 mM and assayed their effect on the phospholipid membrane. For this, we measured the changes in the phospholipid membrane viscosity under various anesthetic concentrations by using fluorescence depolarization method.

Results and Discussions: In the solution without anesthetics, the phase transition temperature of phospholipid membrane was 42 ± 0.17°C. The solutions with 0.1 and 0.2 mM anesthetics indicated no changes in phase transition temperature regardless of iso or sevo. In the solutions with anesthetics at
A-476
Isoflurane enhances inactivation of A-type K channel current in rat substantia nigra
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Background and Goal of Study: The authors previously demonstrated that isoflurane (Iso) increased excitability in principal neurons in rat substantia nigra pars compacta (SNc). We studied effects of Iso on voltage dependent K channels to clarify mechanisms of the increase in excitability in these neurons.

Materials and Methods: Voltage-clamp whole cell recording were made in rat midbrain slices in the presence of tetrodotoxin, cadmium, and bicuculline. We recorded the outward membrane currents in response to the depolarizing voltage steps from -120 mV and -25 mV. We isolated the transient outward current mediated through A-type K channels by subtracting the current traces following the prepulse of -25 mV from those following the prepulse of -120 mV. After baseline recordings were obtained, Iso groups were perfused with the solution bubbled with 1.5 and 3% Iso for 10 min before the recordings were made again, while control group received no Iso.

Results and Discussions: Although the amplitudes of the transient outward current were not different among the groups, exposure to Iso accelerated the decay of the transient outward current resulting in significant decreases in the time to 50% of the peak value (control 1.27 ± 0.19 of baseline, Iso 1.5 % 0.72 ± 0.27, Iso 3 % 0.52 ± 0.1, mean ± SD). Analysis of the inactivation kinetics revealed that Iso delayed the recovery from inactivation without changing steady-state inactivation curves. Iso did not affect the non-inactivating outward current induced by depolarizing voltage steps from -25 mV.

Conclusion(s): These results indicate that Iso accelerated inactivation and delayed the recovery from inactivation of A-type K channels in principal neurons in rat SNc without affecting delayed rectifier K channels. These effects may contribute to excitation of these neurons and Iso-induced increase in spontaneous dopamine release reported in vivo before.

References:
3 Intune M. Anesthesiology 1997; 86: 464–75.

A-477
Modulation of glycine receptors by phenol derivatives
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Background and Goal of Study: The important role of glycine receptors in modulating ascending nociceptive pathways and pain processing (1) makes them a potentially interesting target site for anti-nociceptive and spasmolytic agents. While phenol derivatives constitute a family of potentially neuromodulatory drugs (2), the only compound in clinical use at the present time is the anaesthetic propofol (2,6-disopropylphenol). The aim of our study was to identify structural features in phenol derivatives that determine their modulatory effects at glycine receptors.

Materials and Methods: The effects of four methylated phenol derivatives and two halogenated analogues were studied on chloride inward currents mediated through A-type K channels by subtracting the current traces following the prepulse of -25 mV from those following the prepulse of -120 mV. After baseline recordings were obtained, Iso groups were perfused with the solution bubbled with 1.5 and 3% Iso for 10 min before the recordings were made again, while control group received no Iso.

Results and Discussions: Although the amplitudes of the transient outward current were not different among the groups, exposure to Iso accelerated the decay of the transient outward current resulting in significant decreases in the time to 50% of the peak value (control 1.27 ± 0.19 of baseline, Iso 1.5 % 0.72 ± 0.27, Iso 3 % 0.52 ± 0.1, mean ± SD). Analysis of the inactivation kinetics revealed that Iso delayed the recovery from inactivation without changing steady-state inactivation curves. Iso did not affect the non-inactivating outward current induced by depolarizing voltage steps from -25 mV.

Conclusion(s): These results indicate that Iso accelerated inactivation and delayed the recovery from inactivation of A-type K channels in principal neurons in rat SNc without affecting delayed rectifier K channels. These effects may contribute to excitation of these neurons and Iso-induced increase in spontaneous dopamine release reported in vivo before.

References:
3 Intune M. Anesthesiology 1997; 86: 464–75.

A-478
Ropivacaine attenuates lipopolysaccharide-induced monocyte chemoattractant protein-1 and matrix metalloproteinase-9 production in human monocytes
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Background and Goal of Study: Chemokines and matrix metalloproteinases (MMP) play important roles in inflammatory processes (1). The monocyte chemoattractant protein (MCP-1) is a potent chemo-attractant for monocytes. Matrix metalloproteinases (MMP)-9 helps support the extravasation and infiltration of leukocytes through proteolysis of basement membrane and extracellular matrix(2). The aim of this study was to examine the effect of ropivacaine on lipopolysaccharide-induced MCP-1 and MMP-9 production, as well as MCP-1 induced chemotaxis by human monocyte cell line, THP-1.

Materials and Methods: Cultured THP-1 cells were incubated with LPS and/or ropivacaine (3 x 10^{-5} to 3 x 10^{-3} M). Enzyme-linked immunosorbent assay was used to examine the effect of ropivacaine on MCP-1 and MMP-9 synthesis, and their mRNA expression by THP-1 cells in a dose-dependent manner. MMP-9 activity was also attenuated by 100 μM–3 mM ropivacaine. Furthermore, we demonstrated that ropivacaine suppressed MCP-1 induced chemotaxis.

Conclusion(s): Our results suggest that ropivacaine may modulate inflammatory response, and this appears to be mediated to a significant inhibition of monocyte chemoattractant, as well as LPS-induced MCP-1, MMP-9 production and MMP-9 activity by human monocytes.

References:
mouse brain. In contrast, remifentanil was able to displace \(^{125}\text{I}\)-PIC dose dependently from all \(\alpha_2\)-AR subtypes. At a concentration of 13 mM this displacement was almost complete. In \(\alpha_2\)-AR-KO-mice a reduced signal intensity of specifically bound \(^{125}\text{I}\)-PIC – according to the dominant role of this \(\alpha_2\)-AR subtype – was seen but the displacement by remifentanil was comparable to \(\alpha_2\)- and \(\alpha_2\)-KO mice.

**Conclusion:** Our findings suggest that remifentanil but not sufentanil interacts with all subtypes of \(\alpha_2\)-AR in the central nervous system. This may indicate that clinical effects of remifentanil could be partially mediated by \(\alpha_2\)-AR.

**References:**

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### A-480
**Effect of abdominal surgery with or without vagotomy on tumor cells proliferation in rat**
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**Background:** Immunosuppression in the perioperative period increases susceptibility to infectious complications and tumor cells proliferation (1). Vagus nerve plays a major role in immunomodulation and subdiaphragmatic vagotomy inhibits different acute phase responses (2). The present study evaluates the effect of a subdiaphragmatic vagotomy on tumor cells proliferation in a validated rat model of lungs metastases (3).

**Materials and Methods:** Under sevoflurane anesthesia, adult male Wistar rats (n = 4–6 per group) underwent either a median laparotomy or a laparotomy associated to a subdiaphragmatic vagotomy. In all the rats as well as in a control group of unoperated animals, tumor cells (MADB106, from rodent mammary adenocarcinoma) were intravenously injected in the tail 5 hours after surgery as previously described (3). Three weeks later, animals were euthanized and lungs removed to allow a count of surface metastases. Statistical analysis used ANOVA and posthoc test. \(p < 0.05\) was significant.

**Results:** Pulmonary metastases counts are expressed in Table as mean ± SD (95% CI).

<table>
<thead>
<tr>
<th>Controls</th>
<th>Abdominal incision</th>
<th>Abdominal incision and vagotomy</th>
</tr>
</thead>
<tbody>
<tr>
<td>20.9 ± 14 (10.6–31.2)</td>
<td>51.3 ± 36.8 (20.7–81.8)</td>
<td>107.3 ± 45 (80.6–154.4)</td>
</tr>
</tbody>
</table>

\(p < 0.05\) with Controls; \(p < 0.01\) with control and abdominal incision groups.

**Discussion and Conclusion:** Association of vagotomy to abdominal surgery strongly potentiates the deleterious effect of surgical injury on tumor proliferation. Explanations might be related to the loss of immune control exerted by vagus nerve and maybe to the fact that vagotomy technique by itself involves a more invasive surgery.

**References:**

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### A-481
**Effect of remifentanil on NMDA receptors in rat spinal cord: an electrophysiological study**
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**Background and Goal of Study:** Remifentanil hydrochloride (Ultiva\(^\circ\)) has been incriminated in direct N-methyl-D-aspartate (NMDA) receptors activation (1) whereas DAMGO, an other \(\mu\)-opioid, was described as a modulator of this receptor (2). Nevertheless, the involved mechanisms concerning remifentanil hydrochloride remain unclear. In the present study, direct activation of NMDA receptors and modulation of NMDA-induced current by remifentanil hydrochloride, with and without its vehicle glycerine, were examined on neurons inside the lamina II from the dorsal horn of the rat spinal cord.

**Material and Methods:** Whole cell patch-clamp recordings were performed on acute rats lumbar spinal cord slices. Considering that both components of Ultiva\(^\circ\) (remifentanil hydrochloride and glycerine) could be involved in NMDA receptors activation, experiments were performed first with 50 \(\mu\)M remifentanil hydrochloride, second with 3 mM glycine and third with Ultiva\(^\circ\) containing 50 \(\mu\)M remifentanil hydrochloride plus 3 mM glycine. Modulation of NMDA receptors was examined with 3 \(\mu\)M remifentanil hydrochloride.

**Results and Discussion:** 22 cells were recorded. 50 \(\mu\)M remifentanil hydrochloride do not induce any current whereas 3 mM glycine induce a current that is abolished by the specific NMDA glutamate site antagonist D-2- amino-5-phosphonovalerotate (APV). Ultiva\(^\circ\) (50 \(\mu\)M remifentanil hydrochloride with 3 mM glycine as vehicle) also evokes an inward current that is abolished by APV and not significantly different from the glycine induced current (\(-96.14 ± 10.99\) pA, \(n = 7\) vs \(-94.53 ± 16.29\) pA, \(n = 5\), student's t-test: \(p > 0.05\)). Application of 3 \(\mu\)M remifentanil hydrochloride increases the NMDA-induced inward current by 61.3 ± 13% and this increase is abolished by the \(\mu\)-opioid receptor antagonist naltrexone.

**Conclusion:** remifentanil hydrochloride does not directly activate NMDA receptors. The NMDA current recorded after application of Ultiva\(^\circ\) is related to the presence of glycine. Induced NMDA current is majored by application of remifentanil hydrochloride through a pathway involving the \(\mu\)-opioid receptor.

**References:**

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### A-482
**Effects of oxidative stress and propofol on the activity of glutamate transporter EAAC1 expressed in Xenopus oocytes**
J.-Y. Yun, J.-H. Kim, S.-H. Do, B.-M. Ham, K.-W. Yum, Y.-L. Kim

**Department of Anesthesiology, Seoul National University College of Medicine, Seoul, Republic of Korea**

**Background and Goals:** Although the mechanism of neuroprotective effect of propofol (PPF) is not clarified yet, recent reports suggest that it may be mediated by glutamate transporters. In this study, we investigated whether oxidative stress by tert-butyl hydroperoxide (t-BOOH) decrease the activity of EAAC1, a neuronal subtype of glutamate transporter, expressed in Xenopus oocytes and whether PPF could recover it.

**Materials and Methods:** EAAT3 was expressed in Xenopus oocytes by injection of EAAT3 mRNA. After 3 day-incubation, Xenopus oocytes were exposed to 1, 2, 3, 5, and 10 mM of t-BOOH for 10 min. Using two-electrode voltage clamp, membrane currents were recorded after the application of 30 \(\mu\)M L-glutamate. PPF diluted in Tyrode’s solution to 30 \(\mu\)M was perfused at 4 \(\mu\)L/min over the oocytes preincubated in 5 \(\mu\)M t-BOOH. Responses were quantified by integration of the current trace and compared with control.

**Results:** Data (Mean ± SEM) are shown in the Table. Each set of data has been normalized by using the mean value of the control group from the same batch of oocytes (\(n = 3\) or 4).

<table>
<thead>
<tr>
<th>t-BOOH conc.</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 (control)</td>
<td>1.00 ± 0.06</td>
</tr>
<tr>
<td>1 mM</td>
<td>0.92 ± 0.08</td>
</tr>
<tr>
<td>2 mM</td>
<td>0.72 ± 0.06*</td>
</tr>
<tr>
<td>3 mM</td>
<td>0.66 ± 0.04*</td>
</tr>
<tr>
<td>5 mM</td>
<td>0.70 ± 0.05*</td>
</tr>
<tr>
<td>10 mM</td>
<td>0.57 ± 0.05*</td>
</tr>
<tr>
<td>5 mM + PPF 30 (\mu)M</td>
<td>0.97 ± 0.04</td>
</tr>
</tbody>
</table>

\(p < 0.05\) compared with control. Data are mean ± SEM (\(n = 14–18\)).

**Conclusions:** Oxidative stress by t-BOOH decreased the activity of EAAC1, which was recovered by PPF. This effect of PPF may explain its neuroprotective property.

**Reference:**

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### A-483
**Ketamine increases the intracellular magnesium concentration via Activation of mitogen-activated protein kinase in rat cardiac ventricular myocytes**

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**Background and Goal of Study:** Magnesium is the second most abundant divalent cation in mammalian cellular systems and plays central roles in a multitude of biological processes. In the present study, we have investigated the effect of ketamine on the concentration of intracellular free Mg\(^{2+}\) concentration ([Mg\(^{2+}\)]) and signaling pathways which are responsible for the ketamine-induced modulation of the [Mg\(^{2+}\)].
Materials and Methods: We used the fluorescent dye, mag-fura-2-AM, to measure the intracellular free magnesium concentration ([Mg^{2+}]_i) in isolated rat cardiac ventricular myocytes. To determine the level of phosphorylation of the mitogen-activated protein (MAP) kinases, western analysis of threo-nine/tyrosine phosphorylated MAP kinases was used.

Results and Discussions: Ketamine increased the [Mg^{2+}]_i in a dose-dependent manner with an EC_{50} of 266.61 ± 34.89 μM, and this was independent of extracellular Mg^{2+}/Na^{+} or intracellular BAPTA-AM. The ketamine-induced increase of [Mg^{2+}]_i was highly blocked by the pretreatment with (MAP) kinase inhibitors. Immunoblotting showed that ketamine induced the activation of MAP kinases (ERK1/ERK2, p38 MAP kinase) by increasing the level of phosphorylation of the MAP kinases.

Conclusion(s): These results suggest that ketamine increases [Mg^{2+}]_i in rat cardiac ventricular myocytes, and the ketamine-induced increase of [Mg^{2+}]_i might result from releasing Mg^{2+} from an intracellular pool through a MAP-kinase-involved pathway.

A-484

Dose-dependent neurotoxicity of amitriptyline in vitro

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Background and Goal of Study: Several reports suggest that tricyclic anti-depressants (TCA) may be used topically to provide regional anesthesia and analgesia [1]. However, TCA may exhibit significant neurotoxic potential [1,2]. We therefore investigated clinically relevant doses [2] of amitriptyline as the prototype TCA in an established model of neurotoxicity in vitro.

Materials and Methods: Adult rodent dorsal root ganglion neurons were dissociated and treated with amitriptyline at 0 (control), 0.1 and 0.5 mM for 24 hours, followed by staining with anti-neurofilament antibodies. Neurons were evaluated with regard to survival and axon growth. Subsequently, we performed nuclear staining (Sytox) on neurons incubated with 0.1 mM amitriptyline, to detect cytotoxicity.

Results and Discussions: We found a dose-dependent toxic effect of amitriptyline. The average culture cell count as compared to controls (519 ± 191, n = 6) was decreased following incubation with amitriptyline 0.1 mM (211 ± 103, n = 5, P < 0.05) and 0.5 mM (115 ± 13, n = 6, P < 0.001). Likewise, the number of neurons exhibiting regular neurite outgrowth was diminished compared to controls (131 ± 77, n = 7) following incubation with amitriptyline 0.1 mM (58 ± 42, n = 6, P = 0.06) and 0.5 mM (0.8 ± 1, n = 7, P < 0.05). Sytox staining in neurons incubated with amitriptyline 0.1 mM was significantly increased as compared to control neurons (P < 0.001).

Conclusion(s): Amitriptyline causes a dose-related cytotoxic effect in neurons already at clinically relevant concentrations.

References:

A-486

Interaction of the CB1 agonist ACEA and propofol

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Background: 79-tetrahydrocannabinol (THC) has among many other effects a sedative and an analgesic component. These effects are mediated by specific cannabinoid receptors. Specific cannabinoid receptor subtype agonists and their interaction with i.v. anaesthetics have not been investigated. Goal of this study was to investigate sedation and analgesia in an established mice model after aplication of propofol and ACEA.

Methods: Twenty SV 129 male mice received intraperitoneal (i.p.) injections with permission and according to the state laws of animal safety of propofol and the CB1 agonist ACEA. Sedation was monitored employing a rotating rod. A cut-off time of 60 s was defined as no sedation. Analgesic effects were determined by a tail flick unit with a cut-off time of 10 s to avoid tissue damage.

Results: After i.p. injection of 50 mg/kg of propofol a rapid onset of sedation was measured with a maximum after 2.5 min with 53 s on the rota-rod. There after sedation diminished until 7.5 min post injection, being abolished at this point. Propofol had no analgesic effect. ACEA injection with 5 mg/kg lead to an increase in tail flick latency with a maximum of 8.8 s after 15 min, baseline 3.9 s. The effect slowly diminished and was abolished after ten hours. ACEA showed no significant sedation.

Conclusion: SEVO specifically induces p38 stressskinnase activity in HTL in vitro. This effect seems to be independent of SEVO-associated inflammatory or apoptotic effects.

References:
1 Anesthesiology 1999;91:701–12.

A-487

Sevoflurane activates the p38 mitogen-activated protein kinase in human T-lymphocytes in vitro

M. Roeslein, T. Loop, M. Frick, D. Dovliakue, K. Geiger, H. Pahl, P. Pannen
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Background and Goal of Study: Sevoflurane (SEVO) is believed to mediate cytoprotective preconditioning, a process involving “Mitogen Activated Protein Kinases” (MAPK). The aim of this study was to determine whether SEVO is able to induce the activity of p38-MAPK in human T-lymphocytes (HTL) and if this effect correlates with the inflammatory and apoptotic potentials of SEVO.

Materials and Methods: HTL were incubated with SEVO, isoflurane (ISO), or desflurane (DES). Phosphorylation of proteins was evaluated by “Western Blot”, activity of p38 by kinase assay, DNA-binding activity of the nuclear transcription factor NF-κB (NF-κB) by “Electrophoretic Mobility Shift Assay” and apoptosis by flow cytometry after GFP-annexin-V staining.

Results and Discussion: While DES and ISO had no or little effect, SEVO dose-dependently induced phosphorylation (Fig. a) and activity (Fig. b) of p38. While SEVO increased apoptosis and NF-κB-activity, inhibition of p38 with SB203580 prevented neither DNA-binding of NF-κB (Fig. c) nor apoptosis (Fig. d). In addition, inhibition of apoptosis by Z-VAD.fmk did not prevent p38 phosphorylation (Fig. d).

A-488

Thiopental induces a heat shock response in human T-lymphocytes

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Background and Goal of Study: The induction of a heat shock response is characterised by the activation of the transcription factor HSF-1 and the expression of several heat shock proteins (HSP). The heat shock response is associated with a possible protection of cells and organs. Several inducers of the heat shock response simultaneously inhibit the nuclear factor κB (NF-κB), a central regulator of the immune response. The aim of this study was to determine whether the thiopental-mediated inhibition of NF-κB is associated with an induction of the heat shock response in human T-lymphocytes.
A-489

The effect site half time of sevoflurane for burst suppression is longer than for hypnosis as determined by the bispectral index during routine anaesthesia and surgery

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Background and Goal of Study: The relationship between measures of drug effect such as bispectral index (BIS) and end-tidal (ET) levels of anaesthetic agents is described by the "effect site equilibrium half-time", t\textsubscript{1/2(ke0)}.

There is limited data on sevoflurane t\textsubscript{1/2(ke0)}, and none during routine anaesthesia and surgery. Preliminary observations suggested t\textsubscript{1/2(ke0)} for the degree of hypnosis as estimated by BIS is different from that for egg burst suppression, occurring at "deep" levels of anaesthesia. This study aimed to determine t\textsubscript{1/2(ke0)} for these two "effects".

Materials and Methods: Large changes in ET sevoflurane were produced in 13 patients during routine surgery. ET sevoflurane, BIS and burst suppression ratio (BSR) were recorded every 10s. Data was divided into periods of "high BIS" (BIS >30) or burst suppression (BSR >10%) and t\textsubscript{1/2(ke0)} was determined for each segment using a semi-parametric modeling technique.

Results and Discussions: There were 36 "high BIS" and 20 burst suppression zones. Mean t\textsubscript{1/2(ke0)} for BIS was 3.59 min (SD 1.62 min) and for BSR 9.36 min (5.37 min). When compared with a binomial test these are highly significant differences (p = 0.004).

Conclusion(s): Different eg effect of sevoflurane have different t\textsubscript{1/2(ke0)} suggesting different sites or mechanisms of action. These results also establish values of t\textsubscript{1/2(ke0)} which can be used to provide real-time estimates of effect-site sevoflurane concentration in clinical practice.

Acknowledgements: Supported by a grant from the Canterbury Medical Research Foundation.

A-490

Alfentanil-propropofol co-induction for the insertion of the laryngeal tube airway versus the laryngeal mask airway

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Background and Goal of Study: Laryngeal tube airway (LTA) is a relatively new supraglottic device which, like the laryngeal mask airway (LMA), maintains airway patency during anaesthesia. In a prospective randomised double-blind study we determined the proprofol requirements (ED50) for the insertion of either tube. The ease and complications related to insertion were the secondary outcomes.

Materials and Methods: After Research Committee approval and informed consent, suitable unpremedicated patients aged 18-60 ASA I and II were allocated to the LTA (n = 27) or LMA group (n = 28). Alfentanil 5 μg kg\textsuperscript{-1} I.V. was given to all patients. First patient in each group received propofol 2.5 mg kg\textsuperscript{-1} I.V. for induction. The dose for consecutive patients in either group varied according to Staircase Design method with a step size of 0.5 mg kg\textsuperscript{-1}. Insertion of the device was attempted ninety sec later if mouth was relaxed, always by the same anaesthetist blind to the dose of propofol. Three independent observers described the response to insertion. "Movement" was defined as any coughing, straining, laryngospasm or purposeful limb movements at insertion or within 1 min afterwards, ED50 was determined by calculating the mean of the midpoint dose of 6 independent pairs of patients who manifested crossover from "movement" to "no movement".

Results and Discussions: The ED50 of propofol for insertion of the LTA and LMA was 2.66 (SD 0.86) and 2.33 (SD 0.37) mg kg\textsuperscript{-1}, respectively (p = 0.04).

Time to effective airway was significantly longer (52.85 vs. 33.00 sec, p = 0.0002) and more minor maneuvers were necessary in the LTA patients (p = 0.02). The incidence of airway complications was low and similar.

Conclusion: When alfentanil is used as co-induction agent, insertion of the LTA requires similar induction doses of propofol and it is not associated with an increased risk of complications compared to the LMA.

References:
2. A-491

Effect of hydromorphone premedication on etomidate induction of general anaesthesia, including intubating conditions. A BIS controlled study

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Goal of Study: In a recent investigation, etomidate IV was administered as sole anaesthetic agent for induction of GA in 30 hydromorphone-premedicated patients (1). Bispectral index (BIS) value consistently decreased to 50 for tracheal intubation with no purposeful movement in 29 of those 30 patients. Intubation is a highly reflexogenic phenomenon. Whether hydromorphone premedication accounted for this high intubation rate was presently investigated.

Material and Methods: Sixty-seven ASA I-Ill patients were randomly allocated to receive 1.5 mg/kg oral hydromorphone or placebo 90 min prior to induction of GA using etomidate 0.3 mg/kg IV, given alone. BIS values were continuously recorded. A tourniquet was placed on a lower limb to record purposeful movements. Tracheal intubation was facilitated using rocuronium 0.6 mg/kg IV when the BIS value was 50. Anaesthetic data were compared between patients receiving hydromorphone or placebo. Mann Whitney U-test, Fischer’s test, Student’s t-test were used.

Results: M (range), m = SD, n

<table>
<thead>
<tr>
<th>Hydromorphone (n = 35)</th>
<th>Placebo (n = 32)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of eyelid reflex (sec)</td>
<td>83 (21-210)</td>
<td>97 (30-300)</td>
</tr>
<tr>
<td>Time to BIS ≤ 50 (sec)</td>
<td>100 (21-266)</td>
<td>113 (30-510)</td>
</tr>
<tr>
<td>Time to BIS back to 50 (sec)</td>
<td>431 (100-1429)</td>
<td>325 (75-1599)</td>
</tr>
<tr>
<td>Purposeful movements prior to intubation (yes/no)</td>
<td>7/28</td>
<td>5/27</td>
</tr>
<tr>
<td>BIS at intubation</td>
<td>41 ± 11</td>
<td>48 ± 17</td>
</tr>
<tr>
<td>Successful intubation (yes/no)</td>
<td>26/9</td>
<td>17/15</td>
</tr>
</tbody>
</table>

Demographic data were similar. No recall was recorded.

Discussion and Conclusions: Hydromorphone premedication did not alter etomidate induction of GA including intubating conditions. These findings are in line with previous data (2,3). Indeed, when hydromorphone is compared to placebo in randomised, prospective studies, it produces questionable effects on both preoperative anxiety and postoperative analgesia (2). Moreover, etomidate 0.3 mg/kg IV, given alone, was associated with a 62% likelihood of successful intubation on the first attempt as presently (3). It is of note that the intubation rate was smaller than previously (1). A larger sample size than previously may account for this discrepancy.

References:
A-492
Preoxygenation enhances induction of anaesthesia with sevoflurane as assessed with BIS monitoring
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Background and Goal: Previous studies investigate methods enhancing the speed of inhalational induction of anaesthesia1. In a prospective randomized double-blind study we evaluated the speed of induction of anaesthesia with sevoflurane, with or without preoxygenation.

Materials and Methods: Forty patients scheduled for hysteroscopy under general anaesthesia received for 10 min air or 100% O2 via a face-mask. Anaesthesia was induced with >7% sevoflurane in 100% O2 via a primed circle system. Zipprep™ electrodes were attached to the forehead of the patients for BIS monitoring. BIS values were recorded every 30 s, during the first 300 seconds of sevoflurane administration.

Results: Demographics did not differ between groups. The group which inhaled O2 before induction exhibited significantly lower BIS values when compared to the group that received air (F = 7.97, df = 1, p = 0.009). Means ± SD are shown in Figure 1.

Conclusion: Preoxygenation for 10 min enhances the speed of inhalational induction of anaesthesia with sevoflurane.


A-493
Intravenous infusion of lidocaine reduces sevoflurane requirements during laparoscopic colectomy
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Background and Goals: Intravenous (i.v.) lidocaine (LIDO) is analgesic, anti-inflammatory, and anti-hyperalgesic.1,2 LIDO blocks the NMDA-receptors.3 We therefore tested the hypothesis that LIDO reduces sevoflurane requirements during laparoscopic colectomy (LAPCOL).

Material and Methods: After approval of our institution Ethics Committee, 40 patients scheduled for LAPCOL gave their consent to be included in this randomised double-blind placebo-controlled study. Patients were allocated to two groups: i.v. LIDO (bolus = 1.5 mg/kg before the induction of anaesthesia, then a continuous i.v. infusion 2 mg/kg/h) or saline. Anaesthesia was induced with desflurane, with or without preoxygenation.

Results: No significant difference between the two groups in age, body weight, MAC-hours, the time of cold ischemia of the graft and intraoperative haemodynamic and metabolic parameters was observed. Intraoperative arterial pressure and heart rate were statistically higher in group D. No statistically significant difference was observed in the fluctuation of blood urea with time in either group. Creatinine levels fluctuated with time (towards lower values) significantly both in groups D and I (P < 0.01).

Mean urea and creatinine values did not differ significantly between the two groups at any time of the study.

Conclusion: Postoperative changes in blood urea and serum creatinine after desflurane administration are similar to those observed after the already established isoflurane use in renal transplantation.


A-494
Use of desflurane in renal transplantation. A comparison with isoflurane
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Background and Goal of Study: Aim of this study was the comparison of the postoperative effect of desflurane intraoperative administration versus the established use of isoflurane1, based on biochemical markers of renal function in patients undergoing renal transplantation from living related donors.

Material and Methods: Forty patients with end-stage renal failure who were submitted to renal transplantation were studied. They were randomly allocated to two groups: group D (maintenance of anaesthesia with desflurane) and group I (isoflurane). The anaesthetic protocol was the same in both groups apart from the volatile agent used for the maintenance of anaesthesia.

For the evaluation of postoperative renal graft function, blood urea and serum creatinine changes fluctuation within each group preoperatively and from the first to third postoperative day were compared using two-way analysis of variance. Additionally, mean values of these parameters were compared between the two groups at each time of study by “t−test” (P < 0.05 considered significant). Patients’ demographic data, MAC-hours, cold ischemia time, and intraoperative haemodynamic and metabolic parameters were also recorded.

Results: No significant difference between the two groups in age, body weight, MAC-hours, the time of cold ischemia of the graft and intraoperative metabolic parameters was observed. Intraoperative arterial pressure and heart rate were statistically significant in group D. No statistically significant difference was observed in the fluctuation of blood urea with time in either group. Creatinine levels fluctuated with time (towards lower values) significantly both in groups D and I (P < 0.01).

Mean urea and creatinine values did not differ significantly between the two groups at any time of the study.

Conclusion: Postoperative changes in blood urea and serum creatinine after desflurane administration are similar to those observed after the already established isoflurane use in renal transplantation.


A-495
A single dose of propofol can produce excellent sedation and amnesia in cystoscopic examination
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Background and Goal of Study: Propofol is used to produces sedation and amnesia in patients undergoing invasive investigation and procedures such as dental and vitreoretinal surgery (1,2). Cystoscopy is one of the painful procedures which need to be done under anesthesia or full sedation. In this study we compared sedative and amnestic effects of propofol and midazolam in cystoscopic examination.
Materials and Methods: This study was a prospective clinical trial which was done on 44 adult, ASA I, II, III who were candidate for cystoscopic examination. Patients were divided into two groups according -10 convenience sampling method. Patients were excluded from the study if they had psychological problems, drugs or alcohol abuse, drug’s allergy or pregnancy. Before beginning of the procedure vital signs were registered and then sedation was done with propofol 0.75 mg/kg I.V. plus fentanyl 50 μg in study group and midazolam 3 mg plus 50 μg fentanyl in control group. Then vital signs and SaO2 in 1 and 10 minutes after beginning of examination and numerical patient’s movement were registered during procedure, also frequency distribution of patient’s recall, VAS for pain and satisfaction scores were evaluated in recovery room. All data were analyzed with T test and Chi-Square.

Results and Discussion: There were no statistical differences between two groups for age (p = 0.87), weight (p = 0.83), sex (p = 0.61), ASA physical status (p = 0.57) and duration of examination (p = 0.48) They were a lower VAS pain score and higher VAS satisfaction scores in propofol group (p = 0.009 and p = 0.041 respectively).

Conclusion: We concluded that propofol can produce good sedation and amnesia and also good examination condition in patients undergoing cystoscopic examination.

References:

A-496
Comparison of pupil reflex dilation after 100 Hz tetanus at the end of surgery and postoperative pain under a stable remifentanil concentration
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Background and Goal of Study: Painful stimuli dilate the pupil; this reflex is called pupil reflex dilation (PRD). Opiate drugs such as remifentanil reduce PRD. Our goal was to assess the relationship between PRD in anaesthetised patients at the end of surgery and postoperative pain in order to improve the postoperative pain management during the transition after a remifentanil TCI anaesthesia.

Materials and Methods: Nineteen ASA 1/2 patients undergoing gynaecological surgery were anaesthetised with propofol and remifentanil. At the end of surgery, target effect site concentration (CeT) of remifentanil was titrated to maintain a constant remifentanil CeT of 1.5 ng/ml.

The aim of the study was to assess the neurodegenerative effects of propofol exposure to newborn rats and may induce neurodegenerative mechanisms. Transferability of these results to human beings and possible consequences for the anaesthesiological practice remains to be determined.

References:

A-498
Assessment of recovery from general anesthesia under sevoflurane, desflurane or propofol for long lasting surgery
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Background and Goal of Study: The aim of the study was to assess the recovery profile after long lasting surgery, using different anesthetic maintenance agents.

Materials and Methods: A standardized induction 33 patients undergoing spinal stabilization were randomly assigned to one of the following groups of anesthesia maintenance: a) sevoflurane (n = 10), or c) continuous infusion of propofol (n = 10), titrated to maintain a BIS level of 40–50. Anesthesia was combined with remifentanil infusion and morphine given 30 min before the end of the operation. Measurement was performed during anaesthesia. For statistical analysis t-test with independent-samples was performed.

Results and Discussion: A significant increase in the density of apoptotic cells (p < 0.001) was found in animals treated with propofol (apoptotic score 27558 ± 2738/mm², versus 14438 ± 3659/mm² in controls). Normal pH values were measured and thus severe hypoxia or metabolic disorders could be excluded.

Conclusion(s): Propofol enhances the apoptosis in the developing brain of newborn rats and may induce neurodegenerative mechanisms. Transferability of these results to human beings and possible consequences for the anaesthesiological practice remains to be determined.

References:
A-499

Influence of remifentanil in the prediction of propofol concentration at recovery of consciousness
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Background and Goal of Study: It would be clinically useful to predict the propofol (Prop) effect concentration (PropCe) at recovery of consciousness (ROC). We postulated that a patient’s PropCe at ROC is related with PropCe at loss of consciousness (LOC) and requirements for remifentanil (Remi) during surgery.

Materials and Methods: Neurosurgical patients with Glasgow 15, ASA 1/2, and TIVA with effect site TCI Prop (Schnider1) and Remi (Minto2). Data were collected using RugLoop® software every 5 s from A2000XP® (BIS). Patients were premedicated per os with 10 mg of diazepam. Induction was performed with a Prop constant infusion of 200 ml/hr until LOC. At LOC, Remi started with a plasma target of 2.5 ng/ml, and Prop effect target ( PropCe ) was set to PropCe at LOC. Before ROC the PropCe was gradually reduced and Remi adjusted to patient’s needs (data: mean ± sd).

Results and Discussion: Thirty one patients, age 48.7 ± 15, body mass index 26.5 ± 5, 21 female. PropCe at LOC were 4.9 ± 1 g/ml. Time between the beginning of Prop infusion until LOC was 3.61 ± 0.7 min. PropCe at ROC were 1.16 ± 0.3 µg/ml. Predicted effect Remi concentrations at ROC were 3.41 ± 1.5 ng/ml. Different relations were tested, and a statistically significant (p < 0.05) correlation between PropCe at ROC and PropCe at LOC multiplied by Remi mean dose during surgery (0.12 ± 0.02 µg/kg/min), was observed.

Conclusion(s): The correlation between PropCe at ROC and PropCe at LOC2 was improved by the inclusion of Remi dosage information. This study can be useful in a future ROC prediction model and brings more insight to drug interactions.

References:

A-500

The effect of alfentanil on the localization of epileptogenic focus in pediatric patients with intractable seizure disorder
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Background and Goal of Study: Among the chemical stimulants to activate the electrical activity, opioids are helpful to localize the epileptogenic area. The objective of this study was to confirm the effect of alfentanil on the localization of epileptogenic focus in pediatric patients with intractable seizure disorders.

Materials and Methods: Six pediatric patients (aged 2–16 years old) received an anesthetic induction with thiopental sodium 5 mg/kg, rocuronium 0.6 mg/kg. Anesthesia was maintained with sevoflurane in 50% oxygen with 50% air. After dural opening, sevoflurane was maintained at 0.6% end-tidal concentration during the study.

Electrocoagulation over the surface of the temporal lobe extending to hippocampus and amygdala was obtained, followed by 5 minute of recording. After the administration of alfentanil 20 mg/kg, the abundant spontaneous spiking area before alfentanil activation was defined as the suspected ictal zone. Any changes in cardiovascular variables were documented. Off-line analysis of electrocorticography was done by neurologist according to the changes of number of interictal epileptiform spike of suspected ictal and non-ictal zone before and after the administration of alfentanil. Values are mean ± SD. For statistical analysis Wilcoxon signed rank test was performed.

Results: Alfentanil induced an significant increase in spike activity (20.0 ± 9.3 vs 36.0 ± 18.1 number of spike/1 minute epoch P < 0.05). The site of maximal activation was the hippocampus or amygdala and identical to the suspected ictal zone. No significant activation of the relatively infrequent independent spikes recorded over non-ictal zone was seen after the administration of alfentanil. There were no significant changes in the blood pressure and heart rate after the administration of alfentanil.

Conclusions: Alfentanil activates epileptiform activity in pediatric patients with temporal lobe epilepsy and can be used to assist in the localization of the epileptogenic focus during surgery.

References:

A-501

Combining remifentanil to propofol and etomidate in cardioversion anaesthesia
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Background and Goal: In this study we added remifentanil for using propofol and etomidate in smaller induction doses and to decrease their side-effects in elective external cardioversion (EEC) anaesthesia. We also aimed to compare effects of them on haemodynamic and recovery parameters.

Material and Methods: 40 ASA I–II patients enrolled in this prospective and randomized trial. All patients received 1 µg·kg⁻¹·min⁻¹ remifentanil over 90 sec firstly, then group P received propofol 0.5 mg·kg⁻¹ and group E etomidate 0.1 mg·kg⁻¹ over 15 sec. When OAAS/S scale was 4–5, EEC was applied and this time was noted. Haemodynamic and respiratory parameters, awakening time (AT), time of Aldrete Score 9 was noted, number of shocks, total amount of energy, patient and cardiologist satisfaction and side-effects were compared between groups. Chi-square and independent samples t tests were used in statistical analysis with significance < 0.005.

Results and Discussion: Groups were similar in demographic and baseline data. If we compare with other studies (1) we induced anaesthesia with smaller doses of propofol and etomidate by combining remifentanil. In group P a statistically significant decrease in blood pressure occurred after induction and this time was noted. Haemodynamic and respiratory parameters, awakening time (AT), Aldrete time of Aldrete Score was 9 (Ald 9), number of shocks, total amount of energy, patient and cardiologist satisfaction and side-effects were comparable in both groups. Chi-square and independent samples t tests were used in statistical analysis with significance < 0.005.

Conclusion: We concluded that, although etomidate was having longer recovery parameters and propofol was having less stable haemodynamic and respiratory effects; both were acceptable for EEC anaesthesia. And also we could reduce induction doses and side effects of these drugs by combining remifentanil.

Reference:

A-503

Intubating conditions after administration of remifentanil combined with sevoflurane or propofol without muscle relaxants in adults
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Background and Goal of Study: The combination of remifentanil with propofol provides satisfactory intubating conditions without the need for neuromuscular blocking drugs. The aim of the study was to evaluate the intubating conditions after combination of sevoflurane-remifentanil (SR) compared to propofol-remifentanil (PR) when BIS < 40 without administration of muscle relaxants.

Materials and Methods: Thirty patients ASA I–II, scheduled for elective surgery, premedicated with iv clonidine 2mcg·kg⁻¹, received remifentanil 1mcg·kg⁻¹ before induction of anaesthesia. Patients were randomly allocated (Values reported as mean ± SD in Table). Number of shocks, amount of energy, pain existence, patient and cardiologist satisfaction and side-effects were comparable in both groups. Myoclonus wasn’t seen in any group.

Conclusion: We concluded that, although etomidate was having longer recovery parameters and propofol was having less stable haemodynamic and respiratory effects; both were acceptable for EEC anaesthesia. And also we could reduce induction doses and side effects of these drugs by combining remifentanil.

Reference:
A-504

The comparison of different doses of remifentanil on preventing myoclonus due to etomidate
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Background and Goal of Study: Etomidate is a rapid effective sedative-hypnotic agent, that have minimal cardiovascular and sedative effects. Opioids such as fentanyl, alfentanil and sufentanil are used to prevent myoclonus due to etomidate, in this study we aimed to compare effectiveness of different doses of remifentanil on preventing myoclonus due to etomidate. Patients and Methods: After approval of local ethic committee, 45 patients in ASA-II status, who will get general anesthesia were divided into 3 groups. Solutions of the study were prepared by an independent anesthesiologist as 5 ml solutions. Remifentanil was applied at 0.5 μg.ml⁻¹ dose in the group I, 1 μg.ml⁻¹ in group II and 5 μg.ml⁻¹ in group III. No statistical significance was noted between groups for the time taken for loss of consciousness, the time needed for BIS to fall to <40 as well as the haemodynamic responses following intubation.

Conclusion(s): The combination of remifentanil with either propofol or sevoflurane provides satisfactory intubating conditions without neuromuscular blocking drugs, in patients premedicated with clonidine, with some of the measured parameters being better for the PR group.

Reference:

A-505

The effect of gabapentin on epidural analgesia after lower extremity surgery
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Background and Goal of Study: Recent clinical studies determined that, preoperative oral gabapentin decreased pain scores, morphine consumption and side effects in different surgical patients. In this randomized, controlled trial we aimed to examine whether oral gabapentin could have an effect on postoperative pain, local anesthetic consumption, discharge, side effects, satisfaction and recovery in patients after lower extremity surgery and epidural analgesia.

Materials and Methods: Following ethic committee approval and written informed consent, 40 patients scheduled for lower extremity surgery were randomly divided into two groups. Patients in the group I received oral placebo and those in the group II received 1200 mg gabapentin 1h prior to surgery. Patients received the same drug regimens in the postoperative 2nd and 3rd days in the morning according to their group allocation. Analgesia was induced with propofol and maintained with sevoflurane in 50%O2/N2O with a fresh gas flow of 2 L/min and 2 μg.kg⁻¹ fentanyl i.v. The first loading dose of previously placed epidural anesthesia was given at wound closure(bolus 5 ml 0.125% bupivacaine + 1 μg fentanyl/ml) and PCEA pump was connected (bolus 5 ml, lockout 15 min). During the first 1h in the PACU, then at 4.8,12,16, 20, 24, 30, 36, 42, 48, 60 and 72 hrs patients were evaluated for pain scores, HR, SpO2, MBP, respiratory rate, sedation and PCEA use. Patients were separated from the PCEA when no analgesia was needed for the last 4 hrs (time of separation was noted). Analgesia was continued with p.o. acetaminophen 500 mg as required. The time to first flatus, return of bowel function, and duration of hospitalisation were recorded. Dietary intake and ambulation time were also evaluated. Every morning after operation, patients were assessed for readiness for discharge from hospital.

Results and Discussions: Pain scores, bolus received per 24 hrs (21 ± 3, 15 ± 4.8 ± 5; 14 ± 2, 3 ± 3), PCA use (38 ± 11, 57 ± 9 hrs), acetaminophen use (700 ± 523, 350 ± 400 mg) were lower in the group II (P < 0.05). Patients had higher satisfaction levels (P < 0.001) and were more ready for discharge (P < 0.001). There was no difference between groups in return of bowel function, hospitalization, ambulation and resumption of dietary intake. Gabapentin decreased epidural and oral analgesic consumption while increasing patient satisfaction and readiness for discharge.

Reference:

A-506

The use of lornoxicam in the prevention of pruritus caused by the administration of morphine epidurally
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Background and Goal of Study: The epidural administration of opioids can cause pruritus. One of the mechanisms of opioid-related itching is due to the release of prostaglandines (PGE1, PGE2). One of the mechanisms of opioid-related itching is due to the release of prostaglandines (PGE1, PGE2). In order to prevent pruritus caused by morphine epidurally, we investigated whether lornoxicam could be an effective prophylactic agent.

Materials and Methods: Patients scheduled for total abdominal hysterectomy (40 patients, age 39–65, ASA I–II) gave consent and were randomized into two groups for this prospective double-blinded study. All the patients received epidurally 3 mg morphine plus 7 ml ropivacaine 0.2% before the end of the operation. Group 1 received 8 mg lornoxicam i.v. and Group 2 received 2 ml Normal Saline 0.9% i.v. on induction of anaesthesia. Every 12th hour all the patients received a bolus dose of morphine and local anaesthetic and lornoxicam or placebo respectively. Patients were checked for episodes of pruritus and abdominal pain intensity was assessed with VAS score. Patients were checked before leaving PACU and every 4th hour.

Results and Discussion: Patients in Group I had pruritus at 9% and the control group at 58% (P < 0.05), also VAS score was significantly lower in Group I. Conclusion: The administration of lornoxicam i.v. reduces the incidence of pruritus caused by the administration of morphine epidurally.

Reference:

A-507

Comparison of the effect of remifentanil and fentanyl on myoclonus due to etomidate
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Background and Goal of Study: The most common side effects of etomidate is myoclonus, which can cause pruritus. One of the mechanisms of opioid-related itching is due to the release of prostaglandines (PGE1, PGE2). In order to prevent pruritus caused by morphine epidurally, we investigated whether lornoxicam could be an effective prophylactic agent.

Materials and Methods: Patients scheduled for total abdominal hysterectomy (40 patients, age 39–65, ASA I–II) gave consent and were randomized into two groups for this prospective double-blinded study. All the patients received epidurally 3 mg morphine plus 7 ml ropivacaine 0.2% before the end of the operation. Group 1 received 8 mg lornoxicam i.v. and Group 2 received 2 ml Normal Saline 0.9% i.v. on induction of anaesthesia. Every 12th hour all the patients received a bolus dose of morphine and local anaesthetic and lornoxicam or placebo respectively. Patients were checked for episodes of pruritus and abdominal pain intensity was assessed with VAS score. Patients were checked before leaving PACU and every 4th hour.

Results and Discussion: Patients in Group I had pruritus at 9% and the control group at 58% (P < 0.05), also VAS score was significantly lower in Group I. Conclusion: The administration of lornoxicam i.v. reduces the incidence of pruritus caused by the administration of morphine epidurally.

Reference:
recent studies, fentanyl and alfentanil were reported as the most effective opioids in preventing myoclonus. Our aim is to compare the effect of Remifentanil and Fentanyl on myoclonic muscle activity induced by etomidate.

Materials and Methods: 60 adult patients, ASA III scheduled for general anaesthesia were included. All patients were randomly allocated to receive 1 μg·kg⁻¹ intravenous remifentanil (Group R, n = 20), 1 μg·kg⁻¹ intravenous fentanyl (Group F), or the same doses of normal saline (Group C, n = 20). 60 seconds after the medications were given, induction of anaesthesia was maintained by 0.3 mg·kg⁻¹ etomidate, 1 minute later 0.1 mg·kg⁻¹ vecuronium bromide was given to obtain muscle relaxation and then intubation was performed. After the given doses of remifentanil, fentanyl and the same dose of serum physiologic, the level of sedation was recorded as none, light, mild, heavy and myoclonic movements were recorded as 0 – none, 1 – mild, 2 – moderate (two body segments or two group of muscles moving lightly), 3 – severe (Two or more muscle group in active motion). Injection pain after etomidate was also assessed. Data were analysed by using chi-square test and ANOVA. A value of p

A-509

Haemodynamic effects of two distinct TIVA techniques for induction of anaesthesia
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Background and Goal of Study: Haemodynamic stability during induction is important for safe TIVA. We compared haemodynamic stability using two induction techniques; TCI with propofol (Prop) and remifentanil (Remi) versus constant Prop infusion.

Materials and Methods: Neurosurgical patients with Glasgow 15, ASA 1 to 3, received TIVA. Data were collected using RuggLoop II® every 5 s from a Datex AS3 (HR and MAP) and A2000XP (BIS). Patients were allocated to two induction techniques. Group 1: induction was performed with a Prop constant infusion of 200 ml/hr until LOC followed by Remi. Group 2: induction with an effect site propofol (PropCe) target of 5.0 μg/ml (Schnider) and a plasma Remi target of 2.5 ng/ml (Minto2). Data were collect until LOC.

Results and Discussions: Group 1: 16 patients, age 49.8 ± 16, body mass index 26.7 ± 5.5, 10 female. At awake: MAP 97 ± 13 mmHg, HR 73 ± 18 bpm, BIS 93.7 ± 5.6. Group 2: 16 patients, age 46.6 ± 12.7, body mass index 24.9 ± 3.7, 8 female. At awake: MAP 105 ± 17 mmHg, HR 70 ± 15 bpm, BIS 94 ± 4.54. Demographics, MAP and HR at awake did not differ between groups. Between awake and LOC, MAP and HR did not change in neither group. Main results are shown in table.

Data at LOC

<table>
<thead>
<tr>
<th>Group</th>
<th>PropCe (μg/ml)</th>
<th>RemiCe(ng/ml)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 1</td>
<td>5.1 ± 0.4</td>
<td>0</td>
</tr>
<tr>
<td>Group 2</td>
<td>4.9 ± 0.2</td>
<td>1.68 ± 0.4</td>
</tr>
<tr>
<td>Time to LOC (min)</td>
<td>3.63 ± 0.5*</td>
<td>2.3 ± 1*</td>
</tr>
<tr>
<td>Total Prop (mg/kg)</td>
<td>1.72 ± 0.4</td>
<td>1.5 ± 0.3</td>
</tr>
<tr>
<td>MAP (mmHg)</td>
<td>92.6 ± 16</td>
<td>103.6 ± 19</td>
</tr>
<tr>
<td>HR (bpm)</td>
<td>70.4 ± 14</td>
<td>69.7 ± 12</td>
</tr>
<tr>
<td>BIS</td>
<td>60.6 ± 20.2</td>
<td>62.4 ± 19.5</td>
</tr>
</tbody>
</table>

Data as mean ± SD, statistical significance with *p < 0.05.

Conclusion(s): Both techniques had similar haemodynamic stability until LOC. Time to LOC was significantly shorter in Group 2. Thus, induction with Prop and Remi TCI provides faster LOC and has no adverse haemodynamic effects for the same LOC PropCe.

References:
1 Anesthesiology 1998, 88:1170-82.

Acknowledgements: Portuguese Foundation for Science and Technology.

A-510

Dexmedetomidine sedation in patients with end-stage renal failure
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Background and Goal of Study: Dexmedetomidine (DXM) is a selective α₂ adrenoceptor agonist with sedative, analgesic and sympatholytic effects. The aim of the study was to determine the efficacy and safety of DXM for sedation of patients with end-stage renal failure during the formation of arteriovenous fistula under local anaesthesia.

Materials and Methods: Fifty four ASA II/III patients were randomized to receive either DXM (n = 30, dose: 0.7–1 μg/kg/h during 10 min. followed by i.v. infusion 0.3–0.5 μg/kg/h) or midazolam (MID) (n = 24, dose: 0.04 mg/kg followed by i.v. infusion 0.04–0.08 mg/kg/h). Groups were similar for demographic and clinical factors. Analgesia was provided with brachial plexus block (supraclavicular approach) with 30 ml 0.375% of bupivacaine with adrenaline. Blood pressure (BP), heart rate (HR), oxygen saturation (SpO₂) were recorded every 5 min. Ramsey (R) and McKenzie (M) scales as well as orientation score (0 – none, 1 – orientation in time or place, 2 – orientation in both) were used to assess sedation during and after infusion of the study drug. Time to achievement of R4o and M3o sedation scores and time needed for the individual patient to reach R2o and M1o sedation scores (recovery time) was assessed. Data were analyzed by ANOVA, U-Mann Whitney’s test and Wilcoxon’s test.

A-508

Remifentanil pharmacodynamic in liver transplantation
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Background and Goals: Dysfunction of the hepatic system may alter the metabolism of morphine or elimination of the opioids. Patients with liver disease are more sensitive to remifentanil ventilatory depressant effects. (1) We aimed to examine the haemodynamic response to remifentanil in patients with end-stage of liver disease.

Materials and Methods: With IRB approval, 27 patients undergoing liver transplantation were recruited. Anaesthesia was induced with midazolam 0.03 mg·kg⁻¹ intravenously, fentanyl 0.2 mg·kg⁻¹ and etomidate 0.2 mg·kg⁻¹. Remifentanil was given for tracheal intubation. Anaesthesia was maintained with 0.8% sevoflurane. Cardiac function was assessed using a continuous thermocardiogram output before (Baseline) and 8 min after 0.2 μg·kg⁻¹·min remifentanil infusion (Remifentanil). Statistical analysis were made with t-Student paired test. A p value <0.05 was considered significant.

Results and Discussions: We have study 27 cirrhotic patients: 81% male, mean age 52 yr. The hepatic Child class were: A: 4%, B: 65%, and C: 31%. Haemodynamic result are in Table.

<table>
<thead>
<tr>
<th></th>
<th>Remifentanil</th>
<th>PropCe (μg/ml)</th>
<th>RemiCe(ng/ml)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HR (bpm)</td>
<td>58 ± 10</td>
<td>61 ± 11</td>
<td>0.0007</td>
</tr>
<tr>
<td>MAP (mmHg)</td>
<td>80 ± 17</td>
<td>63 ± 16</td>
<td>0.0001</td>
</tr>
<tr>
<td>MPAP (mmHg)</td>
<td>20 ± 2</td>
<td>21 ± 7</td>
<td>0.62</td>
</tr>
<tr>
<td>CI (l/min/m²)</td>
<td>6.9 ± 1.4</td>
<td>4.4 ± 1.1</td>
<td>0.02</td>
</tr>
<tr>
<td>SVR (mmHg/L)</td>
<td>1295 ± 462</td>
<td>1021 ± 438</td>
<td>0.0001</td>
</tr>
<tr>
<td>PVRI (mmHg)</td>
<td>128 ± 61</td>
<td>132 ± 66</td>
<td>0.51</td>
</tr>
<tr>
<td>LUSWI (cm²)</td>
<td>61 ± 18</td>
<td>47 ± 13</td>
<td>0.0001</td>
</tr>
<tr>
<td>RS(SWI)</td>
<td>11 ± 11</td>
<td>9 ± 4</td>
<td>0.24</td>
</tr>
</tbody>
</table>

Conclusion: Remifentanil reduced cardiovascular parameters in liver disease patients. This result suggest that remifentanil dose necessary to provided analgesia in patients with cirrhosis is less than in patient without liver disease. Remifentanil must be carefully titrated in this group patients.

Reference:
A-511
Endocrine stress response and haemodynamics following intubation. Propofol versus sevoflurane
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Department of Anaesthesia, G. Gennimatas General Hospital, Thessaloniki, Greece

Background and Goal of Study: The stress response to intubation and surgery is characterized by increased secretion of pituitary hormones and activation of the sympathetic nervous system. The aim of the study was to compare the fluctuation of cortisol and glucose levels and the haemodynamic changes following intubation and surgical incision in patients induced with propofol or sevoflurane without the use of muscle relaxants.

Materials and Methods: We studied 30 patients, ASA I-II, aged 25 to 65, scheduled for elective general surgery. Patients were premedicated with clonidine 2 mcg·kg⁻¹ iv and remifentanil 1 mcg·kg⁻¹ bolus followed by an infusion 0.1 mcg·kg⁻¹·min⁻¹ to all patients prior to induction of anaesthesia. Patients were previously randomized in to two groups; the group of remifentanil-propofol (RP) received propofol 2.5 mcg·kg⁻¹ and the group of remifentanil-sevoflurane (RS) received sevoflurane (8% initially, falling to 4–2% subsequently). Intubation was performed when the BIS index became <49 without muscle relaxants. Cortisol and glucose levels were assessed prior to induction of anaesthesia, 5 min after intubation and 10 min after surgical incision. Systolic BP, diastolic BP and heart rate were recorded at the same time. Parametric data were analyzed using student’s t-test.

Results and Discussions: Demographic data were similar among groups. Group RP demonstrated significantly lower cortisol levels (p < 0.05) after intubation. There was no statistical significance noted in the glucose levels or in the haemodynamic response to intubation and surgical incision between the two groups.

Conclusion(s): Our results showed that after intubation of the trachea a greater depression of stress response was observed in the PR group compared with the SR group. This could be considered advantageous in patients with cardiovascular or metabolic disorders.

A-512
Propofol and midazolam versus midazolam alone for sedation following coronary artery bypass grafting
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Background and Goal of Study: Propofol and midazolam both have side-effects and synergistic use of these drugs may be optimal for sedation (1). The aim of this study was to compare the postoperative course of patients sedated with interventional midazolam combined with a constant, low dose of propofol versus interventional midazolam alone for sedation following coronary artery bypass grafting (CABG).

Materials and Methods: 42 patients were prospectively randomized to receive interventional midazolam (n = 22) or interventional midazolam combined with a constant, low dose of propofol (1 mg/kg/h) for sedation following uncomplicated CABG. Isoflurane-based anaesthesia with a maximal dose of 25 μg·kg⁻¹·h⁻¹ fentanyl was used during the procedure. Observational period lasted 5 hours. Incidents of light sedation or pain were treated with repeated iv boluses of midazolam or morphine, respectively. Systolic blood pressure was kept in a range of 100–140 mmHg with the use of nitroglycerin infusion. Haemodynamic stability (automatic recording of HR and BP), usage of interventional drugs as well as extubation and ICU time was compared with the use of ANOVA or Mann-Whitney test and p < 0.05 was considered significant.

Results: Haemodynamic stability was comparable. Recovery times and the usage of interventional drugs were significantly different (see Table).

<table>
<thead>
<tr>
<th></th>
<th>Group I</th>
<th>Group II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conciseness (min.)</td>
<td>183 ± 13</td>
<td>143 ± 76</td>
</tr>
<tr>
<td>Extubation (min.)</td>
<td>512 ± 86</td>
<td>661 ± 229</td>
</tr>
<tr>
<td>ICU stay (hours)</td>
<td>33.6 ± 22.9</td>
<td>32.8 ± 13.5</td>
</tr>
<tr>
<td>Morfine (mg)</td>
<td>5.4 ± 2.8</td>
<td>9.2 ± 6.6</td>
</tr>
<tr>
<td>Midazolam (mg)</td>
<td>2.9 ± 2.4</td>
<td>6.5 ± 4.9</td>
</tr>
<tr>
<td>Nitroglycerin (mg)</td>
<td>9.8 ± 9.5</td>
<td>8.1 ± 7.6</td>
</tr>
</tbody>
</table>

Conclusion(s): Synergistic sedation with low-dose propofol and interventional midazolam is safe and may be beneficial over interventional midazolam after CABG.

A-513
Hemodynamic effects of intraoperative magnesium administration in patients undergoing coronary artery bypass grafting surgery (Preliminary results)
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Introduction: Magnesium, a N-MDA receptor antagonist, provides analgesia as well as attenuating hemodynamic effects during endotracheal intubation (1,2). In this study, we aimed to evaluate the hemodynamic effects of magnesium which has administered intraoperatively in patients undergoing coronary artery by-pass grafting surgery (CABG).

Material and Methods: Forty ASA II–III patients undergoing CABG were enrolled to the study. After standart premedication and prior to the induction, patients in Group I (n = 20) received MgSO₄ 50 mg/kg iv bolus followed by 7 mL/kg/h infusion intraoperatively. Group II (n = 20) received saline. Induction of anesthesia was performed with the same drugs in both groups. Mean arterial pressure, heart rate and peripheral O₂ saturation (MAP; HR; O₂ sat) were recorded before and after induction, after intubation, after skin incision and sternotomy. O₂ in air 50% and sevoflurane 2% were used for maintenance of anesthesia. When hemodynamic measurements elevated more than 20% of initial values, 0.5 mg fentanyl was administered i.v.

Results: Demographic data was similar in both groups. In Group I, MAP and HR did not increase after intubation, incision or sternotomy when compared with previous values. Moreover, MAP and HR were lower in Group I when compared with Group II at all time of measurements.

Discussion: Intubation, skin incision and sternotomy are the most important noxious stimulations which cause hemodynamic response during CABG. The present study suggested that bolus and infusion of MgSO₄ attenuated hemodynamic these responses in CABG.

References:

A-514
Effects of dexmedetomidine and esmolol on hemodynamic response to tracheal intubation
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Department of Anesthesiology, Trakya University Medical Faculty; Edirne, Turkey

Introduction: To investigate the effects of dexmedetomidine and esmolol on hemodynamic response due to endotracheal intubation and incision, we designed this randomized, double-blind, placebo-controlled study.

Material and Methods: After the approval of Ethical Committee, 45 (n = 15 in each) ASA status I–II patients were randomly assigned to receive saline intravenous 10 mL bolus followed by 2 mL · kg⁻¹·min⁻¹ infusion (Group S), or
esmolol 1 mg·kg⁻¹ bolus followed by 250 mcg·kg⁻¹·min⁻¹ infusion (Group E), or dexametomidine 1 mcg·kg⁻¹·iv followed by 0.5 mcg·kg⁻¹·h⁻¹ infusion (Group D), 10 min prior to induction which was performed with propofol 2.5 mg·kg⁻¹ and atracurium 0.6 mcg·kg⁻¹. Systolic and diastolic arterial pressure and heart rate (SAP, DAP, HR) were recorded before, 1 and 5 min after intubation, after surgical incision.

Results: Demographic and initial hemodynamic data of groups were similar. SAP and DAP increased in all groups 1 minute after intubation; in Group S (p < 0.001) and D (p < 0.05) the increase were significant compared with the previous value, whereas in Group E, it was minimal (p > 0.05). Heart rate and DAP increased in Group S (p < 0.001, p < 0.01, respectively) and in Group D (p < 0.05, for both); HR decreased in Group E (p > 0.05). At 5th min after intubation, SAP and DAP changed minimally; HR decreased in Groups S and D, but minimal higher than initial values (p > 0.05). Incision caused increase of SAP and HR in Group S (p < 0.01) and D (p < 0.05).

Discussion: The present study suggests that, the effect of Esmolol on preventing hemodynamic response to intubation and incision is better than dexametomidine.

A-515
Theodrenalin produces transitory contraction of pig coronary artery pre-treated with propranolol
T.I. Usichenko, S. Foellner, Ch. Lehmann, M. Wendt, D. Pavlovic
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Background and Goal of Study: It has been shown that akrinor (AKR), used as a pressor agent at hypotensive patients, produces transitory contraction of pig coronary artery pre-treated with propranolol (1). Since AKR is a mixture of theodrenalin hydrochloride (TDR) and cafedrine hydrochloride (CDR), we examined the effects of each substance on the pig left coronary artery in vitro and compared them to the effects of ephedrine (EDR).

Materials and Methods: The rings (n = 8 per group, 2 mm long) of pig left coronary artery were precontracted with 20 mM KCl and the effects of AKR, TDR or CDR (2 μM) were examined. Some preparations were preincubated with beta-adrenergic blocker propranolol (1.3 × 10⁻⁵ M), alpha-1-adrenergic blocker prazosin (10⁻⁵ M), CGS (adenosine antagonist) or SCH (dopamine receptor antagonist).

Results and Discussions: AKR, TDR and CDR relaxed the preparations pre-contracted with KCl (EC50: 2.96 ± 0.83, 4.09 ± 0.95, and 3.79 ± 0.62) while EDR had no effect. In the preparations pre-incubated with propranolol only AKR and TDR, at concentrations of about 5 × 10⁻⁵ M, produced transitory contractions (% over maximal tension: 71 ± 15, and 49 ± 33). At higher concentrations only AKR produced complete relaxation (EC 50 2.16 ± 0.14) while TDR had only minimal relaxing effect (about 20%). That transitory contraction was abolished by incubation with prazosin. Pre-incubation with CGS or SCH did not influence relaxing property of AKR.

Conclusions: We found that AKR, TDR and CDR relaxed pig coronary artery in vitro. This effect was not mediated by the beta-2 adrenergic, dopamine or adenosine receptors. AKR and TDR produced transitory contraction in preparations pre-incubated with propranolol. These contractions were probably due to alpha-1-adrenergoreceptor stimulation.

Reference:

A-516
The efficacy of esmolol with either sevoflurane, desflurane or propofol in controlled hypotension for middle ear surgery
Department of Anaesthesiology and Reanimation, Sisli Etfal Education and Research Hospital, Istanbul, Turkey

Background and Goal of Study: Controlled hypotension provides a satisfactory operative field by reducing intraoperative bleeding in middle ear surgery. α blockers such as esmolol allow sufficient control of intraoperative blood pressure thus might be valuable for intraoperative conditions for surgeon (2). In our study we aimed to evaluate the efficacy of esmolol as a hypotensive agent and the effects on recovery when combined with either sevoflurane, desflurane or propofol.

Materials and Methods: After the approval by the Medical Ethics Committee of our Hospital, ASA physical status I-II, 51 patients randomized into three groups. Anaesthesia was induced with propofol, fentanyl and atracurium and maintained with sevoflurane (1-2%) in Group S, desflurane (4-6%) in Group D, propofol (4-6 mg·kg⁻¹·h⁻¹) in Group P. Controlled hypotension was induced with esmolol 500 microg·kg⁻¹ followed by a continuous infusion of 50-300 microg·kg⁻¹·min⁻¹ to maintain the mean arterial pressure (MAP) 20% lower than the baseline values. Haemodynamic parameters (systolic, diastolic arterial pressure SAP, DAP, MAP, heart rate – HR, peroperative bleeding, recovery characteristics, side effects were recorded. ANOVA, Mann Whitney U and chi square tests were used for the statistical analyses. P < 0.05 considered as significant.

Results and Discussion: The mean infusion rate of esmolol in hypotensive period was comparable in three groups. HR values were significantly lower in three groups compared with baseline values (p < 0.05). 3 patients in Group P 1 patient in Group S and Group D needed peroperative atropin treatment because of bradycardia. Peroperative bleeding was similar between the groups. Recovery was earlier in Group D compared with Group S and Group P (p < 0.05).

Conclusion: Esmolol combined with sevoflurane, desflurane or propofol enabled controlled hypotension and provided good surgical conditions for middle ear surgery. All three techniques also provided calm and quick recovery.

References:

A-517
Effects of cardiopulmonary bypass on plasmatic concentrations of propofol in patients undergoing coronary artery bypass grafting
Department of Anaesthesiology and Surgical Critical Care, Heart Institute of Sao Paulo University Medical School, Sao Paulo, Brazil

Background and Goal of Study: Cardiopulmonary bypass (CPB) can alter plasma concentrations of drugs (1). The aim of this study was to compare the effects of CPB on plasma concentrations of propofol in patients undergoing coronary artery bypass grafting (CABG) or off-pump coronary artery bypass (OPCAB), and to correlate measured plasma concentrations with those predicted by target-controlled infusion (TCI).

Materials and Methods: Patients scheduled for CABG (n = 10) or OPCAB (n = 10) were anesthetized with sufentanyl, pancuronium bromide and TCI of propofol aiming plasma concentration of 2.0 μg·mL⁻¹. Blood samples were drawn 0, 5, 15, 30, 60, 120 and 240 minutes after induction and at the end of surgery. At the end of surgery TCI of propofol was reduced to 1.0 μg·mL⁻¹ and blood samples were drawn after 5, 15, 30, 60 and 120 minutes and at the end of infusion. After the end of infusion, samples were drawn at 5, 15, 30, 60, 120, 240, 360, 480 and 720 minutes. Plasma concentrations of propofol were measured through high-performance liquid chromatography. The groups were compared one to the other and to TCI predicted concentrations. Data was analyzed through ANOVA.

Results and Discussion: Predicted and measured concentrations of propofol are shown in the Figure. Both were significantly higher in the OPCAB at 120 minutes (3.32 ± 1.76 in the OPCAB and 2.48 ± 1.12 in the CPB group, p = 0.005) and 240 (3.24 ± 2.71 in the OPCAB and 2.23 ± 2.48 in the CPB group, p = 0.02) minutes after the beginning of surgery.

Conclusion(s): Measured concentrations of propofol were higher than those predicted by TCI in both groups, with higher values in the OPCAB group.

Reference:
A-518

Prophylactic administration of ephedrine against hypotensive effect of anaesthetic induction without myorelaxant
F. Vitkovitch, J. Guignard, A. Daboussi, S. Sacrista, O. Fourcade
Department of Anaesthesiology and Intensive Care, Purpan Hospital, Toulouse, France

Background and Goals: The aim of this study was to determine the effectiveness of two prophylactic administrations of ephedrine against hypotensive effect of anaesthetic induction without myorelaxant.

Material and Methods: 60 patients were randomly allocated to one of the 3 groups (n = 20): normal saline bolus and infusion (Control), ephedrine 0.2 mg/kg bolus and normal saline infusion (Bolus group) or ephedrine 0.1 mg/kg bolus followed with 0.1 mg kg⁻¹ h⁻¹ of ephedrine (Infusion group). Anaesthesia was induced with propofol (3 mg/kg) and remifentanil (1 mcg/kg followed with 0.5 mcg kg⁻¹ min⁻¹ until intubation, then 0.2 mcg kg⁻¹ min⁻¹). Mean arterial pressure (MAP) and Heart rate (HR) were measured before and every minute after induction (T0) during 20 minutes. In all groups additional bolus of ephedrine could be administered in case of hypotension (MAP < 60 mmHg).

Results: Evolution of MAP was different in the three groups (Figure). HR was initially significantly higher and patients received more additional bolus of ephedrine in the Bolus group as compared to the Infusion group.

A-519

Additional ondansetron does not enhance the effects of continuous ondansetron infusion during patient controlled analgesia
K. Hwang, S. Lee
Department of Anaesthesiology, Woordul Spine Hospital, Seoul, Republic of Korea

Background and Goal of Study: This study was designed to determine the effectiveness of the continuous infusion of ondansetron for the prevention of postoperative nausea and vomiting (PONV) in intravenous patient-controlled analgesia (PCA).

Materials and Methods: One hundred and sixty patients undergoing spinal surgery were randomized into four groups according to the method of ondansetron administration, placebo (n = 40, group 1), ondansetron 8 mg mixed to IV PCA (n = 40, group 2), ondansetron 4 mg IV before induction or after surgery in addition to 8 mg mixed to IV PCA (n = 40, group 3 or n = 40, group 4). The incidences of nausea, vomiting, and side effects were recorded for 48 hr postoperatively.

Results and Discussions: The incidence of nausea in group 1 (43%) was significantly higher than in the other groups (group 2: 18%, group 3: 15%, group 4: 18%) (P < 0.05), and vomiting was one in group 1.

Conclusion(s): Continuous ondansetron infusion is effective at preventing PONV, but the effects of additional bolus injections to continuous infusion of ondansetron were not different from continuous infusion only.

A-520

Factors influencing postoperative urinary retention in patients undergoing total knee replacement arthroplasty
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Department of Anaesthesiology and Pain Medicine, Seoul National University Bundang Hospital, Seongnam-si, Gyeonggi-do, Republic of Korea

Background and Goal of Study: Postoperative urinary retention is defined as the inability to void with a full bladder during the postoperative period. We investigated the incidence and risk factors of urinary retention following long spinal anesthesia for total knee arthroplasty for total knee replacement arthroplasty.

Materials and Methods: We retrospectively studied a number of factors that may be associated with urinary retention in 98 women (86.6 ± 6.6 yrs, 152.0 ± 5.1 cm, 60.9 ± 9.6 kg). The outcome variable of logistic regression models are urinary retention and severe urinary retention. The potential explanatory variables are age, height, weight, history of hypertension, DM and abnormal urology, heavy bupivacaine dose, types of patient-controlled analgesia, time to regression of spinal block to sacral segments (Tregression), amount of fluid and duration of surgery. We constructed a multiple linear regression model of the time from subarachnoid injection to spontaneous voiding (Tvoiding) in relation to above variables.

Results and Discussions: The overall rate of urinary retention and severe retention were 57.1% and 30.6%. Tregression (RR = 1.009) was identified as significant explanator of an increased probability for urinary retention (P = 0.002). Tregression (RR = 1.017) and DM (RR = 6.8) for severe urinary retention (P < 0.001, P = 0.054). In the multiple linear regression model, three variables – Tregression, age, urological history were identified to have significant values (3.902, 3.107, 2.284) with Tvoiding (P < 0.001, P = 0.003, P = 0.052).

Conclusion(s): Old age, history of DM, abnormal urological history, delayed recovery of spinal anesthesia are risk factors to urinary retention or delayed spontaneous voiding.

References:

A-521

Ketamine antagonized propofol-induced yawning
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Department of Anaesthesiology, Chang-Gung Memorial Hospital, Kaohsiung, Taiwan, Niao Sung Hisan, Taiwan

Background and Goal of Study: Yawning could be activated by propofol or thiopental during induction of anaesthesia and its mechanism is not clear. Animal study showed drug-induced yawning could be inhibited, not potentiated, by GABA agonists (1). Interestingly, ketamine either induced (0.3 and 0.5 mg/kg, i.p.) or inhibited (15 and 30 mg/kg, i.p.) both apomorphine- and amphetamine-induced stereotyped behaviors in rats (2). This prompted us to investigate whether this NMDA blocker could affect the incidence of propofol-induced yawning during the induction of anaesthesia.

Materials and Methods: A prospective, observational study of anesthetics-induced yawning during induction of anaesthesia was conducted in a tertiary medical center (2400 beds). Total of 120 adult patients (ASA I) were recruited in a consecutive manner. IRB approval and informed consent were obtained. Auditory evoked potential, SpO₂, ETCO₂, ECG and NIBP were applied in the patients receiving routine induction procedure with and without pretreatment of ketamine (0.05, 0.1, 0.3, 0.5 and 1 mg/kg, i.v.). The anaesthesia was induced with slow intravenous bolus injection of propofol (1 mg/kg). There were 20 patients in each group. Statistical analysis was carried out using Chi-squared test, SPSS 12.0 (2003).

Results: Under varied concentrations of ketamine (0, 0.05, 0.1, 0.3, 0.5, 1 mg/kg), propofol-induced yawning could be dramatically abolished by ketamine in a dose-dependent manner (50%, 33.3%, 22.7%, 13.3%, 8.3%, and 0%, respectively) and statistically significant p < 0.001 (Fig. 1).
Conclusions: The above results showing that propofol-induced yawning in human beings can be inhibited by ketamine suggest NMDA receptors play an important role in anesthetics-induced yawning.  

References:  

A-522  
Preoperative fructose infusion prevents intraoperative hypothermia  
T. Mizobe, Y. Nakajima, A. Araki, M. Kohno, H. Ueno  
Department of Anesthesiology, Kyoto Prefectural University of Medicine, Kyoto, Japan  

Background and Goal of Study: To reduce the risk of adverse outcomes by perioperative hypothermia, several treatments to prevent hypothermia have been reported including forced-air prewarming, positive end-expiratory pressure (1), and perioperative amino acids infusion (2). Fructose has been reported to elicit a great increase in dietary-induced thermogenesis. Therefore, we investigated whether preoperative fructose infusion could also prevent progressive hypothermia in anesthetized humans.  

Materials and Methods: This study was approved by the ethical committee on human experiments of our university hospital and written informed consent was obtained from all patients. Twenty patients were divided into two groups; preoperative fructose infusion group (2g/kg); and a saline infusion group. Esophageal core temperature and forearm-fingertip skin temperature gradient (an index of peripheral vasoconstriction) were measured (3) for 3h after induction of anesthesia.  

Results and Discussions: There were no significant differences between the two groups in patient characteristics, anesthetic management, or circulatory data during the study. Mean final core temperature 3h after induction of anesthesia was 35.8 ± 0.3°C (mean ± SD) in the fructose group and 35.1 ± 0.3°C in the saline group (P < 0.05). The thermal vasoconstriction threshold, defined as the esophageal temperature that triggered a rapid increase in forearm-fingertip skin temperature gradient, was increased in the fructose group (36.0 ± 0.3°C), compared with that in the saline group (35.6 ± 0.3°C) (P < 0.05).  

Conclusion(s): Preoperative fructose infusion effectively prevents intraoperative hypothermia by increasing the threshold core temperature for thermal vasoconstriction. Fructose infusion can be an alternative treatment for perioperative hypothermia.  

References:  

A-523  
Quazepam, not triazolam, the night before general anesthesia intensifies intraoperative core hypothermia with little effect on preanaesthetic resting energy expenditure  
A. Shido, K. Toyota, T. Nomura, S. Skura, Y. Saito  
Department of Anesthesiology, School of medicine, Shimane university, Izumo, Japan  

Background and Goals: Preanaesthetic sedatives can affect perioperative body temperatures. We previously reported that quazepam, a long acting benzodiazepine, taken the night before surgery intensifies intraoperative core hypothermia (1). We investigated how hypnotics with different durations of action (2) for 3h after induction of anesthetics.  

Materials and Methods: With IRB approval and informed consent, 15 ASA physical status I or II patients scheduled for head and neck surgery in the morning were randomly assigned to three groups to orally receive triazolam 0.25mg (T: 3 males (M)/3 females (F), age 44 ± 20 yr); quazepam 30mg (Q: 2M/3F, age 61 ± 5 yr) or placebo (P: 1M/3F, age 59 ± 11 yr) the night before surgery. Preanaesthetic REE was measured using gas mass spectrometer. Tympanic membrane temperature (Tt) was monitored during general anesthesia with propofol and fentanyl.  

Results and Discussions: Intraoperative Tt of patients in group Q, but not in group T, were significantly lower compared with those in group P (Fig.). There were no significant differences in REE among the groups.  

Conclusion(s): Quazepam (a long acting benzodiazepine), but not triazolam (a short acting benzodiazepine), taken the night before surgery induces profound intraoperative core hypothermia with little effect on preanaesthetic REE.  

Reference:  

A-524  
Comparison of the quantitative effect of ketamine on vascular pain associated with intravenous rocuronium injection  
Y.S. Shin, J.H. Choi  
Department of Anesthesiology and Pain Medicine, Chungnam National University Hospital, Daejeon, Republic of Korea  

Background and Goal of Study: Rocuronium has a high incidence of pain associated with intravenous injection. In this study, we evaluated the quantitative effect of pretreatment with ketamine on the incidence of pain on injection of rocuronium.  

Materials and Methods: Sixty healthy female patients scheduled for general anesthesia were randomly divided into three groups; saline group (n = 20), ketamine 0.2 mg/kg group (n = 20), ketamine 0.5 mg/kg group (n = 20). Each patient received 2 ml of pretreatment solution via 18 G angiocatheter inserted in the dorsal vein of hand. After 30 seconds, 0.6 mg/kg of rocuronium was administered by intravenous route. Anesthesia was induced by 2 mg/kg of propofol. The assessment of pain was made during the injection of rocuronium and the severity of pain was classified as none, mild, severe.  

Results: The pretreatment with ketamine 0.5 mg/kg intravenously significantly reduced the pain compared to the saline group and ketamine 0.2 mg/kg group. The patients pretreated with ketamine 0.2 mg/kg were less likely to suffer severe pain compared to the saline group.  

Table 1. The incidence of pain during the intravenous administration of rocuronium.  

<table>
<thead>
<tr>
<th>Severity of Pain</th>
<th>Group 1 (n = 20)</th>
<th>Group 2 (n = 20)</th>
<th>Group 3 (n = 20)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>2 (10)</td>
<td>3 (15)</td>
<td>12 (60)</td>
</tr>
<tr>
<td>Mild</td>
<td>8 (40)</td>
<td>15 (75)</td>
<td>6 (30)</td>
</tr>
<tr>
<td>Severe</td>
<td>10 (50)</td>
<td>2 (10)</td>
<td>2 (10)</td>
</tr>
</tbody>
</table>

*p < 0.05 compared with Group 1 and Group 2.  
Numbers in parenthesis are percentage.  

Conclusions: The pretreatment with intravenous ketamine 0.5 mg/kg is more effective than ketamine 0.2 mg/kg in alleviating the incidence and severity of pain on injection of rocuronium without significant side effects.  

References:  

A-525  
Low dose dexamethasone vs. ondansetron for antiemetic prophylaxis in breast surgery  
Department of Obstetric and Gynaecologic Anesthesia, Vall d’Hebron Hospital, Barcelona, Spain  

Background and Goal of Study: Although postoperative nausea and vomiting (PONV) remain a common problem after breast surgery, few clinical
trials have compared low dose Dexamethasone with Ondansetron as antiemetic prophylaxis.

Materials and Methods: This is a prospective randomized, double-blind comparative study to assess the efficacy of 4 mg i.v. Dexamethasone vs. 4 mg i.v. Ondansetron during induction of anaesthesia for controlling PONV. 112 women ASA I-II who underwent breast surgery were randomly assigned to Group I-Ondansetron or Group II-Dexamethasone. Diabetic and obese patients were excluded. Numeric variables were compared with parametric or nonparametric tests according to their distributional characteristics. String variables were studied with Chi-square test. P < 0.05 was considered significant.

Results: The 80 cases with a complete chart had a median age of 59 ± 25 years and a mean weight of 65 kg (SD 9.8). The distribution of these variables resulted homogeneous within both groups. Data regarding nausea, vomiting and use of anti-emetic rescue drugs are shown in the Table:

<table>
<thead>
<tr>
<th></th>
<th>1st postural hour</th>
<th>2nd-6th postural hours</th>
<th>7th-24th postural hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group I –</td>
<td>Nausea = 0</td>
<td>Nausea = 2 (8.7%)</td>
<td>Nausea = 4 (13.3%)</td>
</tr>
<tr>
<td>Ondansetron</td>
<td>Vomiting = 0</td>
<td>Vomiting = 0</td>
<td>Vomiting = 0</td>
</tr>
<tr>
<td>(n = 30)</td>
<td>Rescue = 0</td>
<td>Rescue = 4 (13.3%)</td>
<td>Rescue = 4 (8%)</td>
</tr>
<tr>
<td>Group II –</td>
<td>Nausea = 2 (4%)</td>
<td>Nausea = 8 (16%)</td>
<td>Nausea = 0</td>
</tr>
<tr>
<td>Dexamethasone</td>
<td>Vomiting = 2 (4%)</td>
<td>Vomiting = 2 (4%)</td>
<td>Vomiting = 8 (16%)</td>
</tr>
<tr>
<td>(n = 50)</td>
<td>Rescue = 8 (16%)</td>
<td>Rescue = 10 (20%)</td>
<td>Rescue = 4 (8%)</td>
</tr>
</tbody>
</table>

*p - Nausea-p = 1.0, Nausea-p = 0.63, Nausea-p = 0.13
|                  | Vomiting-p = 1.0  | Vomiting-p = 1.0       | Vomiting-p = 1.0        |
| Rescue-p = 0.27  | Rescue-p = 0.69   | Rescue-p = 0.69        | Rescue-p = 0.62         |

Neither side effects nor complications were observed.

Conclusions: 4 mg i.v. Dexamethasone resulted as effective as 4 mg i.v. Ondansetron in preventing PONV during the first 24 hours following breast surgery.

No significant differences were found in the antiemetic rescue therapy requirements with these drugs.

Considering the similarity between them in safety and efficacy, Dexamethasone should be preferred for anti-emetic prophylaxis due to its lower cost.

A-526 Melatonin as a premedication for laparoscopic cholecystectomy D. Ionescu, C. Badescu, A. Ilie, I. Acalovschi Department of Anesthesia and Intensive Care, University of Medicine and Pharmacy, Cluj-Napoca, Romania

Background and Goal of Study: There are only a few studies involving the use of melatonin for premedication of anaesthesia. The goal of this study was to compare the effects of melatonin and midazolam, administered as a premedication for laparoscopic cholecystectomy.

Materials and Methods: 45 patients (ASA III) undergoing laparoscopic cholecystectomy were divided in three equal groups. Group 1 included the patients receiving 3 mg melatonin the night before and as a premedication, group 2 included the patients which have received 3.7 mg midazolam using the same protocol as for melatonin and, finally, group 3 included patients receiving placebo tablets. In preoperative period the anxiety and sedation scores as well as the quality of preanesthetic sleep have been evaluated. Postoperatively the anxiety and sedation scores and the number of remembered pictures were evaluated at 15 min, 60 min, 6 h, 12 h and 24 h, respectively. The intraanesthetic opioid consumption and the severity of postoperative pain (on VAS) were evaluated also.

Results and Discussions: The anxiety score was lower in the melatonin group compared with midazolam in both preoperative and postoperative period. The score of remembered pictures was constantly better in the melatonin group. The sedation score was significantly lower in melatonin group postoperatively. Also, the severity of postoperative pain and the intraanesthetic opioid needs were lower in the melatonin group compared with midazolam.

Conclusion(s): Melatonin 3mg p.o. can be successfully administered as a premedication for laparoscopic cholecystectomy, taking in consideration the analgetic effect and the reduced opioid consumption, together with a better anxiety score and better intellectual performances determined in these patients, in comparison with midazolam.

References:

A-528 Anxiolytic effects of propofol with nonsedative doses M. Barros-Pereira, J.M. Pego, N. Sousa Department of Neurosciences Group, Universidade do Minho, Braga, Portugal

Background and Goal of Study: Propofol is a general anaesthetic, which is also used with sedative purposes (1). Other central effects of propofol are still cryptic even though there is a generalized impression that sedative doses of propofol also produce anxiolytic effects. Importantly, it should be remembered that propofol acts putatively on several neurotransmitters systems that mediate anxiety behavior. Taken into account this background, we designed a study in order to investigate the influence of propofol on anxiety using innate anxiogenic situations in rats.

Materials and Methods: Groups of Wistar rats were given intraperitoneal injections of propofol (2 doses of propofol (9mg/kg, Propofol 1%, Fresenius®), or excipient (10% Intralipid, Fresenius®). Five minutes later animals were behaviorally assessed in an open field or an elevated plus-maze tests (which evaluate locomotory activity and anxiety behavior, respectively). A second set of animals was examined in the same experimental paradigms following serial injections of propofol (9mg/kg, Propofol 1%, Fresenius®) during 5 days.

Results and Discussions: The open field test failed to show any significant differences in locomotion between experimental groups, which ruled out any sedative effects of the treatments. Moreover, the elevated plus maze was significantly altered by propofol; specifically, rats injected with once with propofol spent more time in the open arm and less time in the closed arm than controls and, as a consequence, the open arm/closed arm ratio was statistically different. Repeated exposure to propofol produced similar results but additionally revealed an increased number of entrances and explorations of the open arm.

Conclusion(s): The present results clearly demonstrate that propofol displays anxiolytic properties; importantly, these effects cannot be ascribed to the well-known sedative effects of the drug, as they were observed in animals with preserved locomotory activity.

References:

A-529 Propofol infusion requirements are lower in hypothermic cardiopulmonary bypass surgery when a cisatracurium infusion is given V. Boussenaere, G. Cammu, T. Deloof, E. Mortier Department of Anaesthesics, Ghent University Hospital, Ghent, Belgium

Background and Goal: Infusions of neuromuscular blocking drugs (NMBDs) are commonly used during cardiac surgery. In two consecutive studies, we investigated whether a continuous infusion of cisatracurium reduces the requirements for propofol during hypothermic cardiopulmonary bypass (CPB) surgery (28°C).

Materials and Methods: In the first study1, 20 patients were randomly assigned either to group 1 (n = 10) or group 2 (n = 10). Anaesthesia was induced with diazepam 0.15 mg/kg-1 and suxamethonium 2.5 mg/kg-1 i.v. Those in group 1 were given a bolus dose of cisatracurium at induction and thereafter no more NMBD. Those in group 2 received a continuous infusion of cisatracurium during the entire procedure at a rate of 1 μg kg-1 min-1 before CPB, 0.75 μg kg-1 min-1 during CPB, and 1 μg kg-1 min-1 following CPB. Anaesthesia was maintained with oxygen 40% in air, propofol 1–3 mg/kg-1 h-1 and boluses of suxamethonium. Propofol dose requirements were adjusted according to BIS monitoring; the BIS was kept between 45% and 55%.

In the second (present) study, groups 1 and 2 (each n = 15) had received a standardised anaesthetic with BIS-guided, propofol target-controlled infu- sion and a remifentanil infusion steered by haemodynamic changes. Group 1 received a cisatracurium bolus dose at induction; group 2 a continuous infusion. The only methodological difference between the two investigations was thus a remifentanil infusion in the second rather than boluses of suxamethonium and diazepam.

Results and Discussions: In the first study, the propofol dose requirements in patients receiving a continuous infusion of cisatracurium during hypothermic CPB surgery were 3.6 ± 0.7 mg kg-1 h-1 and significantly different from those not receiving a maintenance dose of cisatracurium (4.7 ±

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Background and Goal of Study: Propofol dose requirements were lower in patients receiving a total of 150 nonpremedicated patient scheduled for aesthetic surgery were randomly assigned to receive either sufentanil (S) and propofol (prop) was monitored, intra and postoperative cardiovascular and respiratory data were collected. Pain visual analogue scores, consumption of analgesics and nausea and vomiting (PONV) were recorded. Results and Discussion: All the patients were similar in demographic parameters and ASA.

A-532
Inhibitory effects of sevoflurane on U-wave in ECG
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Background and Goal of Study: The genesis of U wave in ECG is not clear, although several hypotheses have been proposed. Sevoflurane, like other volatile anaesthetics, could inhibit transsarcolemmal Ca influx in in-vitro experiments. The present study was therefore to evaluate the possible effects of sevoflurane on U wave in human beings.

Materials and Methods: Perioperative ECG recordings (lead II) were collected and analyzed from 220 gynecologic patients (20 to 70 years old, ASA class I). Anesthesia was induced with thiopental, fentanyl and succinylcholine and maintained with sevoflurane and O2. U wave amplitude was measured from amplified ECG records manually.

Results: Discernible U waves in variable size could be identified in 75% of the patients. A negative correlation between RR interval and Uamp (r = -0.72) supported tachycardia-augmented nature of U wave in the presence of sympathetic stimulation. Uamp was larger in extraordinary beats (442 ± 151% of the control, n = 5, p < 0.05). Sevoflurane (1 to 1.5 MAC) significantly and reversibly suppressed Uamp (a decrease by 55 ± 13 μV, n = 5, p < 0.05) (Fig 1).

Conclusions: The inhibitory action of sevoflurane on Uamp suggests a role of afterdepolarizations and intracellular Ca overload on the genesis of U wave in ECG.

Figure 1. Suppressive effects of sevoflurane on U-waves in ECG. A: pre-induction; B-D: sevoflurane; E: emergence. Example of U-waves in each trace is denoted by arrows.
A-533

Prognosis value of ECG abnormalities, myocardial specific enzymes and cardiac function in spontaneous subarachnoid hemorrhage

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Background and Goal of Study: Spontaneous subarachnoid hemorrhage (SAH) causes myocardial dysfunction in 9 to 23 p.cent, associated with ECG abnormalities. Prognostic value of myocardial injury is unclear. We studied this changes in term of prognosis (Glasgow outcome scale).

Materials and Methods: We prospectly studied 51 patients the first 24 hours after SAH. Patients with chronic cardiac disease or brain death were excluded. Clinical characteristics (Glasgow scale, heart rate, systolic blood pressure), cardiac enzymes (troponin I, total serum creatine kinase and myocardial isoenzyme, myoglobin), ECG changes (ST-T changes, prolonged QT and corrected QT intervals), echocardiographic assessment of cardiac function (left ventricular ejection fraction, hypokinesia) were studied on the day of the admission.

Results and Discussions: Data are shown in the Table.

<table>
<thead>
<tr>
<th>Predictors</th>
<th>Univariate</th>
<th>Multivariate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DR p</td>
<td>OR 95% CI</td>
</tr>
<tr>
<td>Glasgow scale &lt; 13</td>
<td>15.11 &lt;0.05 3.1-73.8</td>
<td></td>
</tr>
<tr>
<td>WFNS &gt; 3</td>
<td>10.71 &lt;0.05 2.6-44.4</td>
<td></td>
</tr>
<tr>
<td>Systolic &lt; 100 mmHg</td>
<td>3.47 &lt;0.05 0.8-14.5</td>
<td>7.58 &lt;0.1 1.4-41.3</td>
</tr>
<tr>
<td>Heart rate &gt; 95 bpm</td>
<td>11.07 &lt;0.05 2.1-64.2</td>
<td>19.32 &lt;0.1 3.1-119.3</td>
</tr>
<tr>
<td>Pneophylephrine used</td>
<td>3.6 &lt;0.05 1-13</td>
<td></td>
</tr>
<tr>
<td>QT prolongation</td>
<td>3.75 &lt;0.05 1.0-13.6</td>
<td></td>
</tr>
</tbody>
</table>

Conclusions: Only systolic blood pressure <100 mmHg and heart rate >95 bpm were found to be independent factors of poor outcome. Measurements of myocardial specific enzymes and echocardiographic assessment of cardiac function have no prognostic impact in this study.

A-535

Deep neuromuscular-block reversal with Org 25969

Department of Anaesthetics, Queens University of Belfast, Belfast, United Kingdom

Background and Goal of Study: Org 25969 is a novel γ-cyclodextrin developed for the reversal of neuromuscular block which acts by encapsulation of the steroidal neuromuscular blocking agents (1). The aim of this multi-centre, randomised, phase II trial was to explore the dose-response relation of Org 25969 given after a prolonged rocuronium-induced neuromuscular block.

Materials and Methods: Thirty adult patients aged 19–76 years with anticipated duration of anaesthesia of ≥2.5 h were anaesthetised using an IV anaesthetic technique. Neuromuscular monitoring was carried out using accelerometry in a train-of-four (TOF) mode with TOF-watch SX. Patients received an initial dose of 0.6 mg/kg of rocuronium followed by increments to maintain a deep level of block at post-tetanic count (PTC) of 1~10 assessed every 6 min. At recovery of T2 following 2 h of deep block, 6 patients each were randomly allocated to receive 0.5, 1.0, 2.0, 4.0 or 6.0 mg/kg of Org 25969. Anaesthesia and neuromuscular monitoring were continued for 30 min after reversal. The primary efficacy variable was the time from start of Org 25969 administration to recovery of TOF ratio to 0.9. Data were analysed by weighted nonlinear regression. Heart rate, blood pressure and any adverse effects were recorded and patients followed up for 7 days.

Results and Discussions: There was a dose-related decrease in the time taken to attain a TOF ratio of 0.9 from 6.8 min with the 0.5 mg/kg dose to 1.4 min with the 4.0 mg/kg dose (see Table for mean (SD) values).

Regression analysis showed the fastest achievable time to TOF ratio of 0.9 to be 1.59 min. Doses of Org 25969 with which the recovery to TOF ratio of 0.9 would occur in a time which would be 4 or 1 min slower were estimated to be 0.74 and 1.39 mg/kg respectively. There were no serious adverse events related to Org 25969 nor was there any evidence of recurrance.

Conclusion(s): A dose-response effect was seen for the time to recovery of TOF ratio to 0.9. Org 25969 was shown to be efficacious and well tolerated.


Acknowledgements: This study was supported by a grant from Organon NV, The Netherlands.

A-536

Intravenous dexamethasone administered perioperatively does not cause hyperglycaemia – initial report

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Background and Goal of Study: In view of the reports questioning the neuroprotective effect of dexamethasone – due to its rapid hyperglycaemic effect [1] we have performed an initial prospective analysis of blood glucose levels in patients administered i.v. dexamethasone perioperatively during neurosurgical procedures.

Materials and Methods: 46 non-diabetic patients (29 women, 17 men; mean age 52 ± 8 yrs) undergoing extensive cranial base surgery were administered dexamethasone i.v. acc. to the following protocol: 8.0~16 mg i.v.; and then 8 mg i.v. every 6 hours. Blood glucose levels were checked every 30 min, before the initial dose, and every 30 mins for the 2 hours, and then every 2 hours during the day of surgery. No glucose was administered intraoperatively, while after surgery the patients received 2000 ml of 5%. Glucose/0.9% saline 2:1 solution in a constant infusion.

Results and Discussions: Blood glucose levels remained at a mean value of 82 ± 12 mg% throughout surgery and did not exceed 118 mg% in the postoperative period during the glucose infusion. No significant increases of the blood glucose level were observed in any of the patients.

Conclusion(s): Intravenous dexamethasone appears not to cause rapid hyperglycaemia in non-diabetic neurological patients. This is an initial communication and it launches further research.


Paediatric Anaesthesia and Intensive Care

A-537

Risk score to predict postoperative vomiting in children

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Background and Goal of Study: Risk scores to predict the occurrence of postoperative vomiting (PV) or nausea and vomiting (PONV) that were developed for adult patients do not fit for children since several risk factors are difficult to assess or are usually not applicable in pediatric patients (e.g. smoking status) [1]. Thus, the aim of the present study was to develop and to validate a simple to predict postoperative vomiting in children (POVLC-score).

Materials and Methods: Development and validation of the new score was based on data of 1257 children (0–14 years) from four independent institutions undergoing various types of surgery under general anesthesia without anteriphractic prophylaxis. The study was approved by the local ethics committee. Preoperatively, several potential risk factors were recorded. Postoperatively, the occurrence of PV was observed for up to 24 hours. The dataset was randomly split into an evaluation set (n = 657) that was analyzed using a forward logistic regression technique and a validation set (n = 600) that was used to confirm the accuracy of prediction by means of the area under a ROC-curve.

Results and Discussions: Four independent risk factors for PV were identified in the final analysis: duration of surgery >30 minutes), age >3 years, strabismus surgery, and a positive history of PV in the children or PV/PONV.
in relatives (mother, father, or siblings). The incidence of PV was 9%, 10%, 30%, 55%, and 70% for 0, 1, 2, 3, and 4 risk factors observed. Using these incidences as cut-off values in the validation dataset, the AUC under the ROC-curve was 0.72 (95% confidence interval: 0.68-0.77).

**Conclusion:** The present data suggest that PV can be predicted with an acceptable accuracy using a 4-item simplified risk score. However, this model must be validated in other institutions before its widespread use can be recommended.

**Reference:**

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**A-538**

**Meta-analysis of post-operative vomiting in children receiving propofol or sevoflurane for induction or maintenance of anaesthesia**

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**Background and Goal of Study:** In adults, intravenous anaesthesia (IVA) reduces PONV. We used meta-analysis to determine whether similar benefits occur in children.

**Materials and Methods:** We identified all prospective randomised studies before 2004 comparing PONV after propofol for induction and maintenance of anaesthesia (PP); propofol for induction and sevoflurane for maintenance (PS), sevoflurane for induction and maintenance (SS) or sevoflurane for induction and propofol for maintenance of anaesthesia (SP).

Using S-Plus, odds ratios were calculated using fixed-effects and random-effects meta-analysis. The number-needed-to-treat (the mean number of patients that if induced and maintained with propofol would save one incidence of PONV) was determined.

**Results and Discussions:** Eleven trials (807 patients) reported vomiting incidence. Seven trials compared PP with SS. 29% of the 312 patients anaesthetised with PP and 35.9% of 315 patients receiving SS vomited. The common odds ratio (fixed effects) was 0.409 (95% CI: 0.277, 0.605) i.e. a 2.4-fold reduction in risk of vomiting. The test for heterogeneity was not significant. The common odds ratio (random effects) was 0.938 (95% CI: 0.211, 4.177) i.e. no significant reduction. The test for heterogeneity was not significant. The common odds ratio (random effects) was 0.938 (95% CI: 0.211, 4.177).

One trial compared PP and PS and 1 trial compared PS and SS.

**Conclusion:** Children receiving a propofol-based anaesthetic had a significantly lower incidence of postoperative vomiting in comparison to children receiving a sevoflurane-based anaesthetic, regardless of the type of surgery, and the observation period of PONV. The magnitude of this benefit is smaller than previously reported for adults. Patient numbers for comparisons other than PP vs SS were small and limit the ability to draw clear conclusions.

**Acknowledgement:** Partial funding from AstraZeneca.

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**A-539**

**Preincisional i.v. clonidine prevents agitation during recovery from sevoflurane anesthesia in children**

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**Background and Goal of Study:** Clonidine seems to prevent agitation from sevoflurane in children. The aim of this study was to estimate the effect of clonidine on agitation as well as on BIS, cardiovascular changes, postoperative pain and recovery conditions after sevoflurane anesthesia.

**Materials and Methods:** Fifty four paediatric patients, ASA I–2, aged 2 months to 12 years, scheduled for elective surgery, were randomly allocated into two groups (A: clonidine 2 mcg/kg; B: saline). After induction with sevoflurane and remifentanil and when BIS <30 children were intubated without muscle relaxant. Clonidine or saline was administered before surgical incision. Anaesthesia was maintained with sevoflurane in a N2O/O2 mixture and remifentanil. At the end of surgery, children were extubated when BIS > 80. BIS values, mean arterial pressure (MAP) and heart rate (HR) were recorded before and after administration of clonidine or saline. Children were blindly evaluated for agitation using the modified Aldrete scoring scale and a “score 0–2” scale (0 = no agitation, 1 = cough during extubation, 2 = agitation, cyanosis, cough). Pain was evaluated with VAS (a ten points scale).

**Statistical analysis** was performed with independent-samples t-test or χ2-test as appropriate.

**Results and Discussions:** Demographic data were similar in both groups. Changes on BIS, MAP and HR before and after administration of either clonidine or saline were not significantly different in both groups. Pain score, Aldrete score 0–2 score are shown on the Table.

**Conclusion:** According to the results of this study, preincisional clonidine prevents agitation from sevoflurane anesthesia in children and decreases postoperative pain, without delaying recovery.

**Reference:**

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**A-540**

**Perioperative anxiety and postoperative behavioral disturbances in children: comparison between induction techniques**

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Department of Anaesthesiology and Reanimation, Hacettepe University Faculty of Medicine, Ankara, Turkey

**Background and Goal of Study:** Induction with sevoflurane inhalation is associated with distress on emergence from anaesthesia and with postoperative behavioral disturbances (PBD) such as nocturnal enuresis, hight-mare, crying during sleep, regression in toilet training etc. (1). This study investigates the influence of amnestic effect of propofol addition to inhalation induction on PBD.

**Materials and Methods:** Following ethics committee approval and parental informed consent, 129 ASA I-II children (2–10 years), undergoing elective adenotonsilomy and tonsillectomy were recruited. Parents were not allowed to accompany their child. Unpremedicated children were randomly allocated as Group 1n = 40: Induction with 8% sevoflurane inhalation, Group 2 n = 40: Induction with 2–2,5 mg · kg⁻¹ intravenous propofol, Group 3 n = 40: Induction with sevoflurane 8% inhalation followed by subhypnotic dose of propofol (1,2 mg · kg⁻¹). Anaesthesia was maintained with 2–4% sevoflurane, 50% O2, and 50% N2O. Anxiety on arrival to operating theatre, at anaesthesia induction and 30 min after emergence were assessed. Parents were asked to fill STAI (State Trait Anxiety Inventory) test preoperatively and STAI and Post Hospitalization Behavior Questionnaire test 1 week later to assess children’s PBD. Krukas Wallis test, Wilcoxon test, Bonferroni test, Pared t-test, Student’s t-test, Pearson and Spearman correlation test, Chi square test were used for statistics. P <0.05 was considered statistically significant.

**Results and Discussions:** The anxiety levels were not different at all measurement points (p > 0.05). Preoperative parent’s anxiety level of all groups was high. Preoperative behavioral disturbances in all groups were same. In Group 1, 15% of children and in Group 3, 20% of children but no children in Group 2 had postoperative nightmare and fear of night (p < 0.05). A relation between preoperative anxiety level and PBD was determined (p < 0.05).

**Conclusion:** Add tion of subhypnotic close of propofol to sevoflurane induc tion does not reduce the incidence of PBD seen after inhalation induction. No PBD was seen in intravenous induction group.

**Reference:**

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**A-541**

**Postoperative nausea and vomiting are independent of oculocardiac reflex during squint surgery in children anesthetized with halothane and nitrous oxide**

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Department of Anaesthesia and Intensive Care, University Hospital in Split, Split, Croatia

**Background and Goal of Study:** Postoperative nausea and vomiting (PONV) appear during squint surgery. The data are still controversial about...
interdependence of PONV and oculocardiac reflex (OCR). As was proved in a recent study, rocuronium attenuates OCR. If these two occurrences are dependent, rocuronium is expected to diminish PONV. The goal of this study was to test the possibility of diminishing PONV with 0.4 mg kg⁻¹ of rocuronium and prove their interdependence.

Materials and Methods: ASA I children, 3 through 10 years old (6, 3–10; median, range), undergoing surgery of the medial rectus muscle, were randomly assigned to two groups. In the R group (n = 59), 0.4 mg kg⁻¹ of rocuronium was administered i.v. before intubation. In the C group (n = 60), no muscle relaxant was used. The anesthesia was induced and maintained with halothane and N₂O/O₂ (50/50%). We registered nausea, vomiting and emetic episodes during 0–6, 7–12 and 13–24 h, postoperatively. Nausea was defined as unpleasant sensation with urge to vomit, and vomiting as forceful expulsion of gastric content. Chi-square, and t-test were used for statistical analysis; p < 0.05 was considered significant.

Results and Discussion: There was no difference between groups regarding gender (p = 0.77), age (p = 0.17), body mass (p = 0.77), ET halothane (p = 0.72), or duration of surgery (p = 0.75), and anesthesia (p = 0.67). There was significant difference between groups regarding occurrence of OCR (p = 0.03). Despite rocuronium attenuation of OCR, the occurrence of PONV was not diminished. There were no differences regarding PONV periods among the children in two groups.

<table>
<thead>
<tr>
<th>Group</th>
<th>OCR</th>
<th>PONV</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>R</td>
<td>No</td>
<td>23</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>9</td>
<td>16</td>
</tr>
<tr>
<td>C</td>
<td>No</td>
<td>18</td>
<td>32</td>
</tr>
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<td></td>
<td>Yes</td>
<td>14</td>
<td>28</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>64</td>
<td>55</td>
</tr>
<tr>
<td>P</td>
<td>0.963</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Conclusions: Rocuronium (0.4 mg kg⁻¹) does not diminish the appearance of PONV. We could not find association between OCR and PONV during squint surgery in children anesthetized with halothane and nitrous oxide.

A-542
Transcutaneous electrical acupoint stimulation versus ondansetron in the prevention of postoperative vomiting following pediatric tonsillectomy
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Department of 1st Anaesthesiology and Reanimation, Numareh Research and Training Hospital, Ankara, Turkey

Background and Goals: We aimed to evaluate the efficacy and side effects of either transcutaneous electrical acupoint stimulation (TEAS) or ondansetron compared to a control group receiving no treatment in the prevention of postoperative vomiting.

Material and Methods: This study (randomized, controlled, prospective) was carried out for 90 children, aged between 4 and 12 who went through tonsillectomy under general anesthesia. In the acupuncture group, electrical stimulation on acupoints (Neiguan and Shangwan) was performed. The second group received a single dose of ondansetron (0.15 mg kg⁻¹). No treatment was given to a control group. The frequency of vomiting attacks and side effects were noted on the day of surgery (in the Postanesthesia Care Unit, in the Day Surgery Care Unit and after discharge) and on the first day after surgery.

Results: There was a significant difference between the treatment groups when compared with the control group in the incidence of emetic episodes occurring in the Day Surgery Care Unit and on the day of surgery after discharge (p < 0.001). In the ondansetron group, side effects were seen in more patients than in the other groups (p < 0.001).

Conclusion: The application of TEAS on sedated children could be an easy, painless (1), reliable and effective method (2) for the prophylaxis of PONV in pediatric tonsillectomy.

References:

A-546
Role of postoperative hyperglycaemia after paediatric heart surgery
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Background and Goal of Study: Hyperglycaemia is an often encountered stress response reflecting the severity of acute illness. Prognostic relevance of this phenomenon in paediatric critical care is poorly understood. Our objective was to determine the association between hyperglycaemia and morbidity after paediatric heart surgery.

Materials and Methods: A cohort of 389 consecutive patients were reviewed, who were admitted between January 2003–December 2003 to our postoperative intensive care unit (PICU). Logistic regressions were performed to analyze the role perioperative variables, particularly the one of hyperglycaemia in prolonged (>72 h) PICU stay, cardiac failure and serious infection.

Results and Discussions: Univariate analysis showed strong relationship between hyperglycaemia and each outcome variable. Multivariate model revealed that intraoperative transfusion (ml/kg; OR: 1:04; 95% CI: 1:01–1:06), intraoperative cumulative isotonic index (OR: 1:65; 95% CI: 1:21–2:24), glucocorticoids on the day of surgery (OR: 0:16; 95% CI: 1:21–2:24) and maximum blood glucose level (>14 mg/dl on the first postoperative day (10 mg/dl; OR: 1:11 95% CI: 1:01–1:21) were independent predictors of prolonged PICU stay (Hosmer–Lemeshow test: 8:13; p:0:42). Hyperglycaemia remained also determinant of cardiac failure in the final multiple model.

Conclusion(s): Postoperative hyperglycaemia is associated with longer ICU stay and cardiac complications in patients underwent paediatric cardiac surgery.

A-545
Premedication with oral midazolam with or without parental presence
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Background and Goal of Study: Most children prefer to stay with their parents even premedicated with oral midazolam and it is not easy to control anxiety on separation from parents at the entrance to the operating room (1, 2). The aim of this study was to determine if parental presence with oral midazolam premedication is effective than midazolam alone.

Materials and Methods: Sixty ASA I–II children undergoing surgery were enrolled in the study. Children were randomized to receive either 0.5 mg · kg⁻¹ midazolam (Group M) or 0.25 mg · kg⁻¹ midazolam with parental presence (Group MP) or parental presence alone (Group P). The child’s anxiety, sedation and separation score was evaluated by 1–4 points of anxiety score (AS), 0–4 of University of Michigan Sedation Score (UMSS) and 1–4 point of parental separation score (PSS) at the entrance to the operating room and tolerance to the face mask. Heart rate (HR), mean blood pressure (MBP) and O₂ saturation (%) were assessed by repeated intervals before and after induction. At the end of surgery the child’s modified Aldrete and Krolik recovery score, AS, PSS, UMSS, FLACC and objective pain scale (OPS) were also assessed.

Results and Discussions: There were no difference between groups in age, sex, weight, and duration of surgery and anesthesia. MBP changes were similar between groups but HR was high in Group M before and after induction of anesthesia (p < 0.05). UMSS was greater both in Group M and PM in the preoperative period (p < 0.05). Success rates for anxiolysis and separation were higher in Group M and PM than Group P (p < 0.05). During recovery, the AS and UMSS was higher and FLACC and OPS was lower in Group M and PM than Group P.

Conclusion(s): Premedication with midazolam results in significantly better anxiolysis and parental separation tolerance, but midazolam with parental presence provides the best condition for children in the operating room.

References:

A-546
Is dexamethasone is a good alternative to ondansetron in preventing postoperative vomiting after paediatric tonsillectomy
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Background and Goal: Postoperative vomiting (POV) is a frequent complication in children after tonsillectomy (1). The aim of this study was to compare the effects of a single dose of dexamethasone versus ondansetron on the incidence of early and late POV and oral intake in children undergoing tonsillectomy.

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Material and Methods: Written informed consent was obtained from the parents of children ages 3–14 years, ASA physical status I or II 100 children scheduled to undergo ambulatory tonsillectomy in this prospective random-ized trial. All children premedicated with oral midazolam 0.5–0.6 mg/kg. General anesthesia was induced by inhalation with sevoflurane. Endotracheal intubation was facilitated with atracurium 0.5 mg/kg. Children were random-ized in to two study medication groups: group I, ondansetron 0.15 mg/kg, maximum 4 mg and group II, dexmethazone 150 μg/kg, maximum 8 mg. Anesthesia was maintained with sevoflurane in nitrous oxide and oxygen. Each patient received an acetaminophen 30 mg/kg suppository via rectum before the start of surgery. Muscle relaxant antagonists were not used.

The incidence of early (0–6h) and late (6–24h) vomiting, the time to first oral intake (FOI), the quality of early (on the ward) and late (after discharge) oral intake (0–1 = excellent, 4 – poor), parental satisfaction (PS: 1 – excellent, 4 – poor) and pain scores in PACU (1 = no pain, 5 = highest pain score) were compared in groups. Chi-square and Student’s t-tests were used in statistical analysis with significative p < 0.05.

Results and Discussion: The demographic data, the duration of surgery and anaesthesia were comparable between groups. Early POV was seen lower in group I (p = 0.046), but late POV was lower in group II (p = 0.026).

Group I Group II

<table>
<thead>
<tr>
<th>Pain</th>
<th>Group I</th>
<th>Group II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain</td>
<td>(1.5)</td>
<td>(1.2)</td>
</tr>
<tr>
<td>Pain</td>
<td>27 (40%)</td>
<td>31 (62%)</td>
</tr>
<tr>
<td>Pain</td>
<td>40 (80%)</td>
<td>47 (94%)</td>
</tr>
<tr>
<td>Pain</td>
<td>0.030*</td>
<td>0.002*</td>
</tr>
</tbody>
</table>

Values reported as mean ± SD; *p < 0.05.

Conclusion: We concluded that single dose of dexamethasone 150 μg·kg⁻¹ is as effective as ondansetron 0.15 mg·kg⁻¹ for the prevention of POV. Besides, for quality of oral intake dexmethasone was better than ondansetron.

References:

A-547
Pain on propofol injection in 160 preschool children: are a new formulation and lidocaine useful?
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Background and Goal of Study: Pain on injection prevents propofol (PPF) anesthesia in children. Mixing lidocaine to PPF is widely used to reduce pain (1). A new solvent (MCT/LCT) has been advocated to be less painful than standard (LCT) PPF (2). No information is available in preschool children, in whom painful injection is especially unsuitable. We designed a prospective, random-ized, double-blind, placebo-controlled study to assess injection pain with two different PPF emulsions with or without lidocaine in children <7 years.

Methods: 160 ASA I–III children undergoing elective surgery were randomly assigned to receive in 30 s for induction of anesthesia: PPF-LCT or PPF-MCT-LCT, 5 mg/kg, with lidocaine 0.5 mg/kg or saline. Age, weight, SpO₂, NIBP, HR, site and size of venous cannulation were recorded in each patient. From spontaneous verbal and motor reaction during injection, each grade 0 to 3, was derived a pain score graded 0 to 6. Results are presented as median and [range]. Kruskall-Wallis and Mann and Whitney tests were used for statisti-cal analysis.

Results: All groups were comparable with regard to all data except pain score descriptive data:

Group n Pain score Pain score <3 (%)
1: pff-lct-saline 39 3 (0–6) 41.0
2: pff-lct-lidocaine 41 1 (0–5) 77.5
3: pff-mct-lct-saline 39 1 (0–5) 76.3
4: pff-mct-mct-lidocaine 41 0 (0–4) 92.5

Pain decreased significantly in all groups vs 1, in 4 vs 3 & 2 but not between 3 & 2. Unsuitable pain (score > 3) virtually disappeared in group 4.

Conclusion: Induction of anesthesia in preschool children with PPF-MCT-LCT caused significantly less pain than with PPF-LCT. Mixing lidocaine to PPF resulted in a further significant reduction of injection pain with both PPF emulsions. Premixing lidocaine to PPF-MCT/LCT resulted in median pain score = 0.

References:

A-548
Lidocaine pretreatment before repeated propofol-based sedation in children undergoing hematologic procedures
F. Biotta, F. Ferri, C. Maurizio, R. Caramia, G. Centola, D. Colagiovanni, F. Araino, M. Pennacchia, V. Karakotch, G. Branca, G. Rosa
Department of Anaesthesiolog, Intensive Care and Pain Medicine, Neuroanaesthesia, Roma, Italy

Background and Goal of Study: In this study we examined the effect of lidoca ine pretreatment prior to propofol administration in children undergoing hemato-logic procedures (bone marrow aspiration, bone biopsy or lumbar puncture).

Materials and Methods: A total of 386 patients undergoing, over a period of 12 months, to 560 hematologic procedures were randomly assigned to receive 2% lidocaine (2.0mg/kg) or an equivalent volume of saline solution 0.9%, 1 minute before the administration of 3mg/kg of propofol. Patients who refused the “milky solution” underwent induction with sevoflurane. A blinded observer measured the presence of pain at site of injection, the incidence of dizziness and vestibular ataxic-like symptoms and patient satisfaction.

Awakening time and postoperative nausea and vomiting were also recorded.

Results and Discussion: Lidocaine pretreatment significantly reduced pain at site of injection compared to placebo (48% vs 12%; p < 0.05). The incidence of neurologic symptoms was significantly reduced with lidocaine pre-treatment compared to placebo (38% vs 2%; p < 0.05). In patients who undergone induction injection awakening time longer and PONV was significantly more frequent than in patients who undergone propofol-based anesthesia induction. Lidocaine bolus injection was more frequently associated to bunts of cough compared to placebo and improve patient parents accept-ance. Parents interview report a lower percentage of dysphonia and agitation in children receiving lidocaine than those receiving placebo before propofol infusion (28% vs. 52%; p < 0.05).

Conclusions: The use of lidocaine pretreatment prior to propofol has been shown to reduce propofol induced pain at the site of injection. The sevoflurane-based induction is associated to higher incidence of postoperative nausea and vomiting and longer time to discharge. We also demonstrate that for short dura-tion sedation-anesthesia in children undergoing repeated hematologic procedur-es the administration of lidocaine 2mg/kg 1 minute before the infusion of propofol reduces dizziness and vestibular ataxic-like symptoms. Bouts of cough associated to lidocaine administration can have a protective role on airway.

A-549
Propofol versus sevoflurane: differences in laryngeal reflex responses in anesthetised children
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Background and Goal of Study: Exaggerated upper airway reflexes are a re-fuse cause for harm in particular during light levels of anesthesia, especially in children. The aim of the study was to determine the role of two most commonly used anesthetic agents in pediatric anesthesia, propofol (P) and sevoflurane (S), in depressing upper airway reflexes depending on the level of hypnosis.

Materials and Methods: 70 children, 2–6 years, scheduled for surgical or dental procedures, were randomly allocated to undergo P or S anesthesia. Premedication was midazolam 0.3 mg/kg and induction of anesthesia with either P or S under spontaneous breathing. Insertion of LMA. The tip of a bronchoscope was placed above the glottic opening. The larynx was stimulated at BIS 40 ± 5 and 60 ± 5 by spraying the vocal cords with 0.2 ml of distilled water. The evoked responses were classified into 3 categories: a) apnea with laryngospasm (complete closure of the glottis >10), b) expiration reflex (forceful inspiration, no preceding inspiration), c) cough reflex.

Results and Discussion: Demographic data did not differ between the groups. In group S 35 patients and in group P 31 patients were analyzed.
Cardiac arrhythmias during general anaesthesia with fentanyl or sevoflurane for cardiac surgery in children

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Background and Goal of Study: We conducted this randomized controlled trial to compare the incidence of arrhythmias during general anaesthesia with fentanyl and that with sevoflurane in children undergoing cardiac surgery for atrial or ventricular septal defect (ASD, VSD).

Materials and Methods: 58 patients, aged 1 mo to 12 yr, who were undergoing ASD or VSD repair were enrolled. Holter-ECG recording was started at least 1 hr before the induction of anaesthesia and stopped after sternotomy were done. Patients who had preoperative arrhythmias or electrolyte imbalance were ruled out from the study. Without premedication, patients were randomly assigned to sevoflurane (n = 31) or fentanyl (n = 27) group. The sevoflurane group was induced with sevoflurane and vecuronium and the fentanyl group was induced with fentanyl, midazolam, and vecuronium. Each group was maintained with the same agents used in induction of anaesthesia under 50% O2 with air. Blood pressure was maintained within 20% of preoperative values in all patients. Chi square test and linear logistic regression analysis are used for statistical analysis and P < 0.05 was considered significant.

Results: The incidence of atrial arrhythmias was not different according to agents used but the incidence of ventricular arrhythmias was significantly higher in sevoflurane group (odds ratio 3.05, 95% confidence interval 1.04–9.92).

Fentanyl (%, n) Sevoflurane (%, n)
Atrial 40.7 (11/27) 48.3 (15/31)
Ventricular 40.7 (11/27) 67.7 (21/31)*
Both 11.1 (3/27) 32.2 (10/31)*

Conclusion(s): The overall incidence of cardiac arrhythmias during general anaesthesia with fentanyl or sevoflurane was very high in patients with VSD or ASD. The incidence of ventricular arrhythmias was significantly higher in sevoflurane group compared to fentanyl group.

Pharmacokinetics and pharmacodynamics of propofol in critically ill children

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Background and Goal of Study: We have shown that propofol pharmacokinetics are altered in children after cardiac surgery, but drug action in this age group remains unpredictable. We report on a new study to construct a pharmacokinetic-pharmacodynamic (PK-PD) model of propofol in this setting with the aim of improving predictability. The collection of further PK data also allowed validation of our previously constructed PK model.

Materials and Methods: This was a prospective study of 10 children (0.4 to 7.7 years, 6.4 to 22.6 kg) emerging from propofol anaesthesia following cardiac surgery. We collected blood samples (for propofol analysis) and electroencephalography (EEG) data during a stepped wake-up, where the propofol infusion rate was reduced from 4 mg kg−1 hr−1 in 1 mg kg−1 hr−1 steps at 30 minute intervals. A sequential population PK-PD analysis was performed using NONMEM software. Age, weight, height, BSA, gender and propofol infusion duration were investigated as model covariates.

Results and Discussions: The pharmacokinetics of propofol were 3-compartmental and weight-proportional. Simulations of propofol infusions using this and our previous model were in good agreement. Initial attempts to model using more traditional EEG variables (spectral edge frequency, % power in 0.5–2Hz band) were unsuccessful, hence a summation of high to low frequency ratios was used. A sigmoid Emax model with an effect compartment best described the PD response, with age as a model covariate.

Conclusion(s): Although substantial inter-patient variability remained, age was a significant covariate affecting Cmax and indicated an increased sensitivity to propofol in younger children. The values for Kmax (typically 0.3 min−1) and propofol concentrations at arousal (median effect site concentration 0.9 µg mL−1) were similar to those observed in adults.

Ketamine reduce pain score and morphine requirement in children after tonsillectomy

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Background and Goal of Study: Tonsillectomy by dissection is painful during postoperative period and responsible for postoperative complications for paediatric patients. Low dose ketamine was efficient to reduce postoperative pain in adult. The goal of this study was to evaluate the effects of low dose ketamine on postoperative pain in children scheduled for tonsillectomy by dissection.

Materials and Methods: After approval by the regional institutional human studies committee and parental consent, 60 ASA physical status I–II pediatric patients undergoing tonsillectomy by dissection were included in a prospective, double blinded, randomised, multicenter study. Children receiving non-steroid anti-inflammatory were excluded. Anaesthesia was conducted with sevoflurane and sufentanil (0.2 mcg kg−1). Sufentanil was only given one time before tracheal intubation. Ketamine (0.3 mg kg−1) or placebo (P) (saline solution) was administered at incision. Patients, medical staff and nurses were blinded of the treatment during and after surgery. All children were extubated in the operating room and transferred in recovery room. They received morphine (50 mcg kg−1)* if Objective Pain Score (OPS) [1] was higher than 3 after administration of paracetamol (15 mg kg−1). Primary outcome measurement was OPS after surgery. Morphine requirement was noted. Wilcoxon and Khi square tests were used for statistical analysis.

Results and Discussions: Thirty children received K and 30 P. OPS after surgery were shown in table 1. Forty percent patients in the K group have no postoperative morphine requirement (10% in the P group; p < 0.0001). Ketamine reduce significantly OPS and morphine requirement after tonsillectomy in children compared with placebo.

Table 1. OPS (median; min-max), *P < 0.05.

<table>
<thead>
<tr>
<th>Time</th>
<th>15'</th>
<th>30'</th>
<th>60'</th>
<th>4 h</th>
<th>8 h</th>
<th>12 h</th>
<th>16 h</th>
</tr>
</thead>
<tbody>
<tr>
<td>K</td>
<td>0 (0–0)</td>
<td>0 (0–0)</td>
<td>0 (0–0)</td>
<td>0 (0–0)</td>
<td>0 (0–0)</td>
<td>0.3 (0–2)*</td>
<td>0 (0–2)*</td>
</tr>
<tr>
<td>P</td>
<td>3 (0–8)</td>
<td>1.5 (0–6)</td>
<td>0 (0–0)</td>
<td>0 (0–0)</td>
<td>1 (0–5)</td>
<td>1.2 (0–6)</td>
<td>0.3 (0–3)</td>
</tr>
</tbody>
</table>

Conclusion(s): Ketamine can be used to improve pain management of tonsillectomy in children.

Reference:

Comparison of morphine and tramadol by patient controlled analgesia (PCA) for postoperative analgesia after tonsillectomy in children

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Background: Tramadol is an alternative to opioids for postoperative pain management (1). This prospective, randomized, double blind study was designed to compare the analgesic efficacy of patient-controlled tramadol with patient-controlled morphine on postoperative pain after tonsillectomy in children.

Methods: Sixty patients were allocated randomly to receive a PCA with either tramadol (T) or morphine (M), in a double-blind randomized study. When surgery was completed and haemostasis achieved, a standardised loading dose (0.1 mg kg−1 group M, or 1 mg kg−1 in group T) was given. Patients were allowed to use bolus doses of the study solution every 10 minutes without a time limit. Scores for pain, sedation, nausea, and the bolus and total PCA doses, haemodynamic parameters and side effects were recorded at 5, 15, 30 minutes and 1, 2, 4, 6 and 24 hours after PCA administration.
Results: Pain scores decreased significantly with time in both groups (p < 0.05), but were lower in group M than in group T at 1, 2 and 4 hours (p < 0.05). Sedation scores increased with time in both groups (p < 0.05). However there were no significant differences in sedation scores between two groups at any study period, but nausea scores were higher in M group at 4, 6 and 24 hours (p < 0.03).

Conclusion: Intravenous patient controlled tramadol is an alternative to patient controlled morphine for postoperative pain relief in children after tonsillectomy. Morphine gave better postoperative pain relief, but was associated with higher incidence of nausea than tramadol.

References:

A-554
Age dependent EEG effect in response to weight normalised propofol dosage in children
Ch. Jeleazcov, J. Schmidt, H. Ihmsen, K. Becke, H. Schwilden, S. Albrecht
Department of Anaesthesiology, Friedrich-Alexander-Universität Erlangen-Nürnberg, Erlangen, Germany

Background and Goal of Study: Intravenous anaesthesia with propofol becomes clinical practice in paediatric anaesthesia. Commonly, drug dosage is body weight normalised (mg·kg⁻¹). This study investigates whether similar weight normalised propofol dosage during surgical maintenance of anaesthesia produces the same EEG effect in children of different ages.

Materials and Methods: We reanalysed EEG data from 31 children aged 1 to 8 years (10 to 25 kg) scheduled for elective minor abdominal surgery. Propofol was administered with weight normalised constant infusion rates of 7.68 ± 1.09 mg·kg⁻¹·h⁻¹ supplemented by remifentanil (0.38 ± 0.06 µg·kg⁻¹·h⁻¹). The EEG effect was assessed by the BIS® recorded with an A1000-monitor. The association between age and weight was investigated by the Pearson r product-moment correlation.

Results and Discussions: Age and weight were linearly correlated (r = 0.92). BIS increased with decreasing age for similar weight normalised infusion (R² = 0.30, Figure).

Conclusion(s): Weight normalised dosage produces different EEG effects in children of different ages. Possible explanations for this finding are: 1) age dependent alterations of propofol pharmacokinetics and – dynamics; 2) age dependent pharmacodynamic interaction of propofol and remifentanil. In addition, changes of the EEG morphology with age cannot yet be ruled out.

References:

A-555
Serum S100B in paediatric head trauma: our experience
O. Piazza, M. Storti, S. Cotena, L.D. Amato, D. Perrotta, F. Stoppa
Department of Anaesthesia and Intensive Care, Federico II, Naples, Italy

Background and Goals: Physical examination, Glasgow Coma Scale score (GCS) and Cranial computed tomography (CT) are the current gold standards for diagnosing traumatic brain injury (TBI), but they have a low sensitivity. Aim of this study is to determine the role of S100B as possible diagnostic test in pediatric TBI.

Material and Methods: We prospectively studied 15 children (age 8.06 ± 2.84 yrs) with head injury. Exclusion criteria were age upper 15 yrs and history of neurological disease. S100B was evaluated on admission and after 48 hours using a immunoradiometric assay. We’ve considered a serum S100B levels ≥0.2 µg/L indicative of cellular injury. CT findings were evaluated using the Marshall classification. Outcome was evaluated after 6 months according Glasgow Outcome Score extend (GOSe).

Results: Data are shown in Table 1.

<table>
<thead>
<tr>
<th>Pat. No</th>
<th>GCS t₀</th>
<th>S100B t₀</th>
<th>S100B t₁</th>
<th>CT t₀</th>
<th>GOSe</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>7</td>
<td>2.88</td>
<td>0.67</td>
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<td>8</td>
</tr>
<tr>
<td>2</td>
<td>15</td>
<td>0.27</td>
<td>0.32</td>
<td>I</td>
<td>8</td>
</tr>
<tr>
<td>3</td>
<td>13</td>
<td>0.32</td>
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<td>1</td>
<td>I</td>
</tr>
<tr>
<td>4</td>
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<td>0.18</td>
<td>I</td>
<td>I</td>
</tr>
<tr>
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<td>0.16</td>
<td>0.18</td>
<td>I</td>
<td>I</td>
</tr>
<tr>
<td>6</td>
<td>14</td>
<td>0.22</td>
<td>0.28</td>
<td>I</td>
<td>I</td>
</tr>
<tr>
<td>7</td>
<td>14</td>
<td>0.33</td>
<td>0.19</td>
<td>1</td>
<td>I</td>
</tr>
<tr>
<td>8</td>
<td>5</td>
<td>1.74</td>
<td>1.06</td>
<td>I</td>
<td>8</td>
</tr>
<tr>
<td>9</td>
<td>15</td>
<td>0.16</td>
<td>*</td>
<td>I</td>
<td>I</td>
</tr>
<tr>
<td>10</td>
<td>11</td>
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<td>0.17</td>
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</tr>
<tr>
<td>11</td>
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<td>1.34</td>
<td>*</td>
<td>I</td>
</tr>
<tr>
<td>12</td>
<td>14</td>
<td>0.19</td>
<td>0.19</td>
<td>1</td>
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<tr>
<td>13</td>
<td>14</td>
<td>0.28</td>
<td>*</td>
<td>I</td>
<td>I</td>
</tr>
<tr>
<td>14</td>
<td>8</td>
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<tr>
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<td>4.15</td>
<td>1.53</td>
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<td>8</td>
</tr>
</tbody>
</table>

The patients were dismissed.
P > 0.05 vs GCS; P < 0.05 vs CT and GOSe.

Conclusions: Despite the restricted number of cases monitored S100B seems to be a promising tool of early detection of TBI when imaging assessment might still be silent. However our results don’t suggest a predictive or prognostic value of S100B for long lasting neurocognitive abnormalities after TBI.

References:

A-556
Evaluation of an anesthetic protocol associating propofol and alfentanil for paediatric fiberoptic bronchoscopy
F. Babre, M. Bordes, F. Sermijn, A.M. Cros
DAR IV, Centre Hospitalo-Universitaire, Bordeaux, France

Background and Goal of Study: Anaesthesia with sevoflurane for paediatric fiberoptic bronchoscopy is used routinely. However, in severe bronchopulmonary disease, because of impaired sevoflurane alveolar diffusion, anaesthesia can be difficult to manage (airway reactivity, obstruction and hypoventilation). The aim of this study was to evaluate if anaesthesia with propofol and alfentanil can prevent the respiratory problems occurring with sevoflurane.

Materials and Methods: This prospective study included children older than one month over a three-month period. Induction was performed with bolus of propofol (less than 3 years: 5 mg·kg⁻¹; 3–8 years: 4 mg·kg⁻¹; over 8 years: 2.5 mg·kg⁻¹) and bolus of alfentanil (10 mcg·kg⁻¹). Maintenance was performed by a propofol infusion (respectively 18, 15 and 10 mg·kg⁻¹·h⁻¹). Local anaesthesia was performed by the endoscopist. Children were oxygenated by mask during the procedure and ventilated if necessary. If coughing, stridor, or laryngospasm occurred, 0.5 mg of lornoxicam was administered by mask during the procedure and ventilated if necessary. If coughing, stridor, or laryngospasm occurred, 0.5 mg of lornoxicam was administered by mask during the procedure and ventilated if necessary.

Results and Discussions: 30 children were included (16 boys, 14 girls, 3.2 ± 3.8 years old, mean weight 14.2 kg). Only 2 children were ASA I. 26 children had bronchial hyper-reactivity. There was a significant relation between additional boluses and the level of inflammation. Respiratory complications (2 laryngospasms, 6 bronchospasms and 19 coughing) were managed by deepening anaesthesia. Spontaneous ventilation was maintained but FeCO₂ was over 50 mmHg. The mean satisfaction rate was good (7.8/10). Calculated plasma concentration (Kataria model) was less than 5 mcg·ml⁻¹·h⁻¹. Mean spontaneous eye opening delay was 33.8 min.

Conclusion: Propofol associated with alfentanil provides a satisfactory anaesthesia for fiberoptic bronchoscopy with few side effects.

References:
A-557

Is there white blood?
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Background and Goal of Study: A case report of an unusually severe presurgical hyperglycaemia and diabetic ketoacidosis.

Materials and Methods: A five years old child was transferred to the Critical Care Unit of our tertiary referral teaching hospital with severe diabetic ketoacidosis complicated by hypertiglycercidaemia.

The presenting complains at the referring hospital were: vague history of lethargy and tiredness lasting for about a week. The first blood glucose test was 29 mmol/l. On transfer the child was stable, self-ventilating, normotensive, Glasgow Coma Scale 15/15, capillary refill of 4 sec, acidicotic (metabolic acidosis with slight compensatory respiratory alkalosis).

On admission of note were the hyperlipidaemia (in excess of 100 mmol/l) and hypercholerolemaemia (more than 30 mmol/l)! On inversion of the invasive monitoring lines the blood was macroscopically white, dense and with high viscosity. Immediate treatment with insulin and fluids according to the protocols of the institution were initiated. Plasmapheresis was considered, but dropped for a later stage of the clinical management. A deep venous thrombosis in the right leg developed as a result of the hyperviscosity.

With time the patient improved and in 48 hours all results went back to normal.

Results and Discussion: This is an unusual presentation of a diabetic ketoacidosis when the biggest clinical problem was the excess in triglycerides secondary to insulin deficiency. The suggesting mechanism is by maximal secretion of lipoprotein lipase enzyme which is known to occur by maximal secretion of lipoprotein lipase enzyme which is known to occur. The possibility of ways of management (heparin, plasmapheresis, etc.) that make this case unusual, difficult and clinically significant.

Conclusion: Diabetic ketoacidosis remains a clinical challenge to critical care physicians who are the ones dealing with the patients when in extremes. The complexity of the problem and its multi-system effects are of paramount importance for the recovery of the patient. As our case shows, despite a respiratory and cardiovascularly stable, the patient can demonstrate untypical and subtle effects of the hyperglycaemia and ketoacidosis.

A-558

The efficacy of IV and peritonsillar infiltration of ketamine for postoperative pain relief in children following adenotonsillectomy
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Department of Anaesthesiology and Reanimation, Hacettepe University Faculty of Medicine, Ankara, Turkey

Background and Goal of Study: Establishment of good analgesia is a major concern in the postoperative period following adenotonsillectomy (1). Our aim is to compare the effects of low dose i.v. and peritonsillar infiltration of ketamine on postoperative pain in children undergoing adenotonsillectomy.

Materials and Methods: Prospective, double-blind placebo controlled study. ASA I-II, 90 children were randomized three groups of each 30. Group I received i.v. 2 ml of saline, Group II received i.v. ketamine (0.5 mg kg⁻¹) and Group III received a local peritonsillar infiltration of 2 ml of ketamine (0.5 mg kg⁻¹), 1 ml per tonsil 3 minutes prior to tonsillectomy. Peritonsillar abscess, allergy of the study drugs and anaesthetic usage in 24 hours prior to surgery were excluded. Anaesthesia and surgical technique were standardized. Modified Hannallah pain scale (OPS) (1), nausea, vomiting, bleeding, rescue analgesia sedation and Aldrete scores were recorded at first, 15th, 30th and 60th minutes postoperatively. Patients were interviewed on the day after surgery to assess the postoperative pain, nightmares, hallucinations, vomiting and bleeding. Repeated measures variance analysis, chi-square and Kruskall-Wallis were performed. p < 0.05 was considered significant.

Results and Discussions: 28 female and 62 male patients with a mean age of 5.88 years (2.20), a mean weight of 20.65 kg (±6.36), and a mean height of 109.75 cm (±15.64) were included. Group I had higher sedation score at 15th minute (p = 0.015), Group II had higher OPS scores (p = 0.000 at first minute, p = 0.05 at 15th minute, p = 0.16 at 30th minute, p = 0.03 at 60th minute) than Group II and Group III. Group II and Group III had similar scores which are not statistically significant (p > 0.05). 32 children, 19 of whom were in Group I had rescue analgesia in PACU (p < 0.05) and the time to reach rescue analgesia was shorter in GI (p = 0.006), GI and Group III had also less pain than GI (p = 0.02). There were no differences between the groups regarding the incidence of adverse reactions.

Conclusions: Low dose ketamine given i.v. or by peritonsillar infiltration perioperatively provides efficient pain relief without side effects in children undergoing adenotonsillectomy.

Reference:

A-559

Intraocular pressure measurement in children under general anaesthesia with sevoflurane
A. Dominguez, F.J. Garcia-Miguel
Department of Anaesthesia and Reanimation, General Hospital of Segovia, Segovia, Spain

Background and Goal of Study: To identify normal values of intraocular pressure (IOP) in children, is required for congenital glaucoma diagnosis and treatment. Sevoflurane is a potent and low-irritant volatile agent, so it can be used for anaesthetic induction and maintenance in children. The aim of this study is to develop a feasible procedure of general anaesthesia for the measurement of the IOP in children and to determine the sevoflurane effect on the IOP, using sevoflurane end-tidal and bispectral index as reference.

Material and Methods: 30 children undergoing botulinic toxin injection for strabismus correction, under general anaesthesia with sevoflurane, were analysed. Induction was performed with sevoflurane inhalation with tidal volume technique at 8% concentration. IOP was measured once anaesthesia was induced and subsequent to botulinic toxin administration, sevoflurane was stopped up and IOP was measured minutely until the child’s recovery.

Results and Discussion: Figure 1 shows IOP values all along the procedure. All of them were into normal range. The lowest IOP values were obtained just before awareness, when bispectral index showed light sedation scores.

A linear regression analysis revealed a statistically significant correlation between IOP and end-tidal sevoflurane (Pearson coefficient = 0.40; p = 0.0009) and between IOP and bispectral index (Pearson coefficient = 0.51; p = 0.0008).

Conclusions: Sevoflurane inhalation with tidal volume technique at 8% concentration has been useful for IOP measurement in children. IOP drop due to sevoflurane was 10%. In our study, we have showed a significant correlation between IOP values and bispectral index and end-tidal sevoflurane values.

References:

A-560

Comparison of caudal ketamine with lidocaine or tramadol administration for postoperative analgesia of hypospadias surgery in children
M. Gunduz, M. Ozalevli, H. Ozbek, D. Ozcengiz
Department of Anaesthesiology, Cukurova University, Adana, Turkey

Background and Goal of Study: This study was designed to investigate whether the addition of tramadol or lidocaine to caudal ketamine would enhance the quality of intra and postoperative analgesia and reduce the sevoflurane requirement for hypospadias surgery in children.

Material and Methods: Sixty two ASA I or II children, between 1 and 10 years of age, scheduled for hypospadias surgery were recruited. Anaesthesia was induced with 6–8% sevoflurane and maintained with 0.5–2.5% sevoflurane-50% N₂O in oxygen. Children were allocated randomly to receive one of two study drugs. Children in group KL received caudal ketamine (0.25 mg · kg⁻¹) plus lidocaine (2 mg · kg⁻¹) and in group KT received caudal ketamine (0.25 mg · kg⁻¹) plus tramadol (1 mg · kg⁻¹). Sevoflurane requirement, systemic blood pressure, heart rate, peripheral O₂ saturation, sedation and pain scores (CHEOPS) were recorded at 1st, 5th, 10th, 15th, 30th, 45th min and 1st, 2nd, 3rd h following recovery from anaesthesia.

Results and Discussion: Duration of analgesia was similar between two groups (p > 0.05), CHEOPS scores were found to be lower in KL group than...
in KT group throughout the study period, except at the first 15 minutes. Sevoflurane requirement was significantly lower in group KL than in group KT perioperatively (p = 0.000). Sedation scores were significantly higher in group KL than in group KT at the first 10 minutes (p < 0.05). Incidence of postoperative nausea and vomiting was similar between two groups (p > 0.05).

Conclusions: Caudal ketamine (0.25 mg kg−1) plus lidocaine (2 mg kg−1) significantly reduced sevoflurane requirement and provided better analgesia quality in postoperative period compared with ketamine (0.25 mg kg−1) plus tramadol (1 mg kg−1).

A-561 Ultrasound guidance reduces the amount of local anaesthetic for ilioinguinal blocks in children
Department of Anaesthesia, Medical University of Vienna, Vienna, Austria

Background and Goal of Study: Regional anaesthesia is a cornerstone in paediatric anaesthesia today. Successful regional anaesthesia provides conditions for light and haemodynamic stable General Anaesthesia and is an essential part of postoperative pain management. The so called ilioinguinal block is one opportunity to achieve adequate analgesia in inguinal hernia or hydrocele repair. In a recently submitted paper, our group demonstrated, the big advantage of Ultrasound guidance in ilioinguinal Blocks (1). This study was designed to evaluate, if US guidance in ilioinguinal blocks reduces the amount of local anaesthetic.

Materials and Methods: After ethic committee approval and parental consent, 40 children, aged between 1–8 years, were included in the study, designed as a step down approach to find the correct dose. Due to prior findings the starting dose of the trial was 0.2 ml/kg 0.25% L-Eubupivacaine. In all patients the ilioinguinal block was performed under US guidance using a portable Sonosite 180 plus US machine and a 10 MHz high resolution linear US probe. Intra and postoperative quality of the block was assessed by a staff anaesthetist, who was blinded to the amount of local anaesthetic. An increase in HR and/or blood pressure of 15% from baseline was assessed as lack of analgesia and treated with 1 µg/kg Fentanyl. Postoperative an OPS Score more than 11 was treated with 0.3 mg/kg Paracetamol rectal.

Results and Discussions: A success rate of 100% (10 out 10) was achieved with 0.2 ml/kg and 0.1 ml/kg. With a dose of 0.05 ml/kg 0.25% L-Eubupivacaine in 3 out of 10 children additional analgesia was necessary at skin incision performed 15 min after block performance. Therefore the dose was increased to 0.075 ml/kg. In this group the success rate was again 100%.

Conclusion(s): Conccordant with previous studies in that field (2) we showed that ultrasonographic guidance offers the advantage for a significant reduction of local anaesthetics for ilioinguinal nerve blocks.

References:
1 Ultrasonographic guidance for ilioinguinal and iliohypogastric nerve block in children Willschke et al submitted for publication.
2 Ultrasonographic guidance reduces the amount of local anaesthetic for 3-in-1 blocks. Marhofer et al RAPM 1998.

A-562 Is cerebral autoregulation preserved in children anesthetised by sevoflurane?
G. Wong, I. Luginbuehl, M. Dolci, C. Karsli, B. Bissonnette
Department of Anaesthesia, Hospital for Sick Children, Toronto, Canada

Background and Goal of Study: The transient hyperemic response (THR) test is a simple non invasive technique to measure cerebral autoregulation using transcranial Doppler. The THR ratio (THRR) provides an index of cerebrovascular autoregulation in healthy adults (1). We aim to evaluate this response in children undergoing general anesthesia.

Materials and Methods: ASA 1 children undergoing elective urological surgery were recruited, each receiving sevoflurane at 0.5, 1.0 and 1.5 MAC in random order. Analgesia was provided by sevoflurane using 0.25% bupivacaine without epinephrine. The middle cerebral artery flow velocities before (F1), during (F2) and after (F3) ipsilateral carotid artery compression were recorded. THRR is calculated by dividing F3 by F1.

Results and Discussions: To date 10 male children aged between 1.4 to 3.2 yrs (1.5 ± 0.7) have been recruited. Results are presented as means (SD) in the following Table.

<table>
<thead>
<tr>
<th>MAC</th>
<th>F1 cm/s</th>
<th>F2 cm/s</th>
<th>F3 cm/s</th>
<th>THR</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.5</td>
<td>120 (20)</td>
<td>126 (19)</td>
<td>125 (26)</td>
<td>1.28 (0.11)</td>
<td>1.18 (0.1)</td>
</tr>
<tr>
<td>1.0</td>
<td>147 (25)</td>
<td>147 (30)</td>
<td>147 (30)</td>
<td>1.28 (0.11)</td>
<td>1.18 (0.1)</td>
</tr>
<tr>
<td>1.5</td>
<td>147 (30)</td>
<td>147 (30)</td>
<td>147 (30)</td>
<td>1.28 (0.11)</td>
<td>1.18 (0.1)</td>
</tr>
</tbody>
</table>

THRR greater than 1.10 have previously been adopted as a lower limit of a normal response (2). The THRR is statistically different between 0.5 MAC versus 1.0 & 1.5 MAC respectively. However, no difference was detected between 1.0 and 1.5 MAC.

Conclusion(s): Preliminary results in this study suggest that THR is present and is maintained under general anesthesia at up to 1.5 MAC of sevoflurane. More patients are presently being studied to further elucidate this response in children.

References:

A-563 Comparison of recovery after desflurane and sevoflurane anaesthesia in children premedicated with midazolam
Department of Anaesthesiology and Reanimation, Sisli Efthal Education and Research Hospital, Istanbul, Turkey

Background and Goal of Study: Oral premedication with midazolam delays early recovery but does not discharge after ambulatory sevoflurane anaesthesia (1,2). Because of low solubility characteristic of desflurane, it gives the anaesthesiologist tighter control over anaesthetic level (3). In this study we aimed to determine if anaesthesia maintenance with desflurane also prolongs recovery as sevoflurane.

Materials and Methods: After the approval by the Medical Ethics Committee of our Hospital and written informed consent from the parents, 40 children (2–6 yr of age, ASA physical status I–II) undergoing tonsillectomy with or without adenoidectomy, received oral midazolam 0.5 mg kg−1 30 min before induction of anaesthesia. Anaesthesia was induced with thiopentone (5 mg kg−1), fentanyl (1 microg kg−1), atracurium (0.5 mg kg−1) and maintained with nitrous oxide/oxygen (50%/50%) and with sevoflurane (0%–5%) in Group S or desflurane (4%–6%) in Group D. Emergence (times to spontaneous ventilation, extubation, response to verbal command) and recovery times (achieving ≥ 9 points on the modified Aldrete scale, duration of PACU stay), side effects were recorded. ANOVA and chi square tests used for statistical analyses. P < 0.05 was considered significant.

Results and Discussion: Demographic data of the patients and duration of operation were similar between the groups. Emergence times were shorter in Group D compared with Group S but the difference was not significant statistically. Recovery times were longer in Group S than Group D (p < 0.05). Side effects did not differ between the two groups.

Conclusion: After oral premedication with midazolam, recovery was later with sevoflurane anaesthesia than desflurane anaesthesia. We conclude desflurane was superior to sevoflurane as an inhalational anaesthetic agent in children undergoing short surgical procedures after midazolam premedication.

References:
1 Bevan JC, Veall GR, Macnab AJ. Anaesth Analg 1997; 85: 50–4.

A-564 Does hypocapnia prevent modification in cerebral blood flow velocity in children when changing from sevoflurane to desflurane anaesthesia?
M. Dolci, C. Karsli, I. Luginbuehl, B. Bissonnette
Department of Anaesthesia, The Hospital For Sick Children, Toronto, Canada

Background and Goal of Study: The effect on cerebral blood flow velocity (CBFV) when sevoflurane (Sev) is changed to desflurane (Des) anaesthesia has been reported, (1) This study was designed to determine if mild hypocapnia can prevent this change in CBFV in children.

Materials and Methods: With REB approval 10 healthy children scheduled for urological surgery were enrolled. Each patient randomly received Sev 1 MAC at either 30 or 40 mmHg end-tidal CO2 (ETCO2) followed by Des 1 MAC at the same ETCO2. The same sequence was repeated at the other ETCO2. CBFV was measured at steady-state for each agent and ETCO2. Heart rate, mean arterial blood pressure and temperature were recorded.

Results and Discussions: The age and weight were 36.6 ± 23.8 mo and 14.3 ± 5.2 kg, respectively. CBFV was higher at ETCO2 40 when compared...
to ETCO2 30 regardless of the anesthetic agent. (P < 0.001, Table) The blood pressure decreased when sevoflurane was switched to desflurane at 30 mmHg and HR remained unchanged (P < 0.01, Table).

Conclusion(s): Replacing sevoflurane with desflurane anesthesia in children may lead to an increase in CBFV if proper control of ETCO2 is not ensured. This might have important considerations in patients with decreased intracerebral compliance.

Reference:

A-565
The effect of hypocapnia and its ability to modify the changes in cerebral blood flow velocity when substituting propofol with desflurane in children
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Department of Anaesthesia, The Hospital for Sick Children, Toronto, Canada

Background and Goal of Study: Facilitating rapid anesthetic emergence by changing from propofol (Prop) to desflurane (Des) anesthesia affects cerebral blood flow velocity (CBFV) (1). This study was designed to determine if mild hypocapnia can prevent this change in CBFV in children.

Materials and Methods: With REB approval 10 healthy children scheduled for urological surgery were enrolled. Each patient randomly received Prop or Des anesthesia. CBFV was measured at steady-state for each agent and ETCO2. Heart rate, mean arterial blood pressure and temperature were recorded when Iso was switched to Des, at either ETCO2 (Table). There was an increase in HR when Iso was substituted with Des at 30 mmHg ETCO2 (P < 0.05).

Results and Discussions: The age and weight were 45.6 ± 15.7 mo and 15.4 ± 2.6 kg, respectively. There were no changes in CBFV or BP when Iso was substituted with Des at 30 mmHg ETCO2 (P < 0.05).

Materials and Methods: With REB approval 10 healthy children scheduled for urological surgery were enrolled. Each patient randomly received Iso MAC at either 30 or 40 mmHg end-tidal CO2 (ETCO2) followed by Des 1 MAC at the same ETCO2. The same sequence was repeated at the other ETCO2. CBFV was measured at steady-state for each agent and ETCO2. Heart rate, blood pressure and temperature were recorded simultaneously.

Results and Discussions: The age and weight were 34.5 ± 19.4 mo and 14.1 ± 3.4 kg, respectively. Heart rate increased and blood pressure decreased with Des compared to Prop, at both ETCO2 levels (P < 0.001). CBFV was higher with Des as compared to Prop, regardless of the ETCO2 (P < 0.001, Table).

Conclusion(s): Switching from Iso to Des anesthesia in order to facilitate rapid emergence appears not to have an effect on CBFV in healthy children.

References:

A-567
Functional residual capacity (FRC) and ventilation homogeneity in anaesthetised children following neuromuscular blockade
B.S. von Ungern-Sternberg, F.J. Frei, J. Hammer, T.O. Erb
Department Anaesthesia, University Childrens Hospital, Basel, Switzerland

Background and Goal of Study: Children under general anaesthesia have a reduced FRC. FRC provides us important information on gas exchange, which is of special importance in children as they are particularly vulnerable for hypoxaemia. However, most studies assessed the overall effect of anaesthesia on the FRC in comparison with the pre-anaesthetic status without regarding the magnitude of contribution of e.g. induction, relaxation, PEEP on their own.

Materials and Methods: We studied 25 children (mean [range] age = 60 [26–77] months, weight = 11.8 [11.2–26.3] kg) without cardio-pulmonary disease, scheduled for elective surgery. Anaesthesia was standardised. FRC was measured using a SF6 mult-breath washout technique. Measurements were taken after 1. intubation, 2. muscle relaxation with rocuronium i.v. and 3. the additional application of PEEP (3 cmH2O). FRC and lung clearance index (LCI) were calculated.

Results and Discussions: FRC significantly decreased following muscle relaxation by 10.1% compared with the FRC measurement following induction while at the same time the LCI increased by 14.3%. FRC values increased by 11.1% after the application of PEEP (3 cmH2O) compared with baseline, whereas the LCI dropped slightly below baseline values (~7%).

Conclusion(s): Neuromuscular blockade leads to a significant decrease of FRC while consistently increasing ventilation inhomogeneity. In contrast, the application of PEEP (3 cmH2O) leads to an increase of FRC simultaneously restores ventilation homogeneity towards baseline values. Therefore the use of “psiologic” PEEP seems rationale in paralyzed children to restore FRC and ventilation homogeneity.

Acknowledgements: The Centiva/5 critical care ventilator used in this study was kindly provided by Anandic.
A-568
Elongation of the trachea during neck extension in children: implication in the safety of endotracheal tube
J.H. Kim, S.H. Do, Y.L. Kim, B.M. Ham, K.W. Yum
Department of Anesthesiology, Seoul National University College of Medicine, Seoul, Republic of Korea

Background and Goal of Study: The uncuffed endotracheal tube (ETT) displacement has been described as changes of the distance between the ETT tip and carina in children. However, the change of the distance between the ETT tip and carina during neck extension may not be equal to the changes of the distance between vocal cords and the ETT tip, which is directly related with the ETT extubation, because of the tracheal elongation.

Materials and Methods: Twenty-five children (2–8 years) were enrolled. Using fiberoptic bronchoscope, distance from ETT tip to carina was measured in the neutral position, after full flexion and full extension of the neck. Then, the distance between carina and vocal cords was measured in the neutral position and after full extension. The distance from vocal cords to ETT tip was calculated as the distance between carina and vocal cords minus the distance from ETT tip to carina.

Results and Discussions:

<table>
<thead>
<tr>
<th>Mean ± SD (cm)</th>
<th>Range (cm)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Tp-Ca) with full flexion</td>
<td>−1.0 ± 0.5</td>
</tr>
<tr>
<td>(Tp-Ca) with full extension</td>
<td>2.0 ± 0.6*</td>
</tr>
<tr>
<td>VC-Ca in neutral position</td>
<td>8.0 ± 0.9</td>
</tr>
<tr>
<td>VC-Ca with full flexion</td>
<td>8.9 ± 0.9</td>
</tr>
<tr>
<td>VC-Ca with full extension</td>
<td>1.0 ± 0.4</td>
</tr>
<tr>
<td>(VC-Tp) with full extension</td>
<td>−1.1 ± 0.5</td>
</tr>
</tbody>
</table>

*p < 0.05 compared with (Tp-Ca) with full flexion.

Abbreviations: (Tp-Ca), change of the distance between carina and endotracheal tube tip; (VC-Ca), change of the distance between carina and vocal cords; (VC-Tp), change of the distance between vocal cords and endotracheal tube tip.

After full extension, the Tp-Ca increased by 2.0 cm. However, VC-Tp decreased only by 1.1 cm.

Conclusions: The tracheal elongation may have an effect of decreasing the risk of ETT extubation during neck extension in older children.

A-569
Effects of modified ultrafiltration on extravascular lung water and intrathoracic blood volume in pediatric patients after cardiopulmonary bypass
T. Palmers, F. Bremer, K. Eberle, T. Ehe, L. Hakami, M. Weyand, R. Csesneyar
Department of Anaesthesiology, University Hospital Erlangen, Erlangen, Germany

Background and Goal of Study: Modified ultrafiltration (MUF) [1] improves haemodynamics and reduces total body water significantly after cardiopulmonary bypass (CPB) in pediatric patients undergoing open heart surgery [2]. In this study we want to determine the effects of MUF on the extravascular lung water (EVLW) as a parameter of pulmonary edema and the changes in intrathoracic blood volume (ITBV) and stroke volume variation (SVV) as parameters for sufficient cardiac filling.

Materials and Methods: After parents written informed consent, 19 patients with minor congenital cardiac defects (ASD n = 12; VSD n = 7) were included in this study. Patients were monitored using the paediatric 3 Fr. PICCO-System introduced via a femoral artery. Haemodynamics were evaluated after discontinuation of CPB and after twenty minutes of MUF. Students-t-test was used, p < 0.05 was considered statistically significant, all data are expressed as mean ± SEM.

Results and Discussions: Beside the previously described increase in mean arterial pressure and cardiac index and a reduction of inotropic support after MUF, we found the following changes:

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Before MUF</th>
<th>After MUF</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>EVLW</td>
<td>12.7 ± 1.1</td>
<td>11.4 ± 0.9</td>
<td>p &lt; 0.01</td>
</tr>
<tr>
<td>ITBV</td>
<td>531 ± 40</td>
<td>558 ± 51</td>
<td>p = n.s.</td>
</tr>
<tr>
<td>SVV</td>
<td>15.5 ± 1.4</td>
<td>16.4 ± 1.0</td>
<td>p &lt; 0.01</td>
</tr>
</tbody>
</table>

Conclusion(s): Based on our data, caudal tube tip displacement during laparoscopy is similar to tube tip displacement during head/neck flexion in children. In all patients intubation depth marks were appropriate to avoid inadvertent endobronchial intubation during laparoscopy.

Reference:

A-570
Tube tip displacement in children during laparoscopy
S. Boetter-Haberzeth, A. Dullenkopf, C.A. Gitzelmann, M. Weiss
Department of Surgery, University Childrens Hospital, Zurich, Switzerland

Background and Goal of Study: Tracheal tube tip displacement during laparoscopy in adults is a well known and studied problem (1). Children have a shorter trachea and are at higher risk for endobronchial intubation during capnoperitoneum and head tilt position. The aim of this study was to investigate tube tip displacement during laparoscopy in children aged from birth to adolescence.

Materials and Methods: With ERB approval and written parental consent 28 children undergoing laparoscopy, were prospectively studied. The patient’s tracheas were orally intubated and the tubes (Microcuff PET) positioned with the depth mark at the level of the vocal cords. The carina–tube tip distance was fiberoptically measured with the patient in (A) 0° position, (B) 20° head tilt, (C) 0° position with capnoperitoneum and (D) 20° head tilt with capnoperitoneum (pressure 10 mmHg). Percentual tube displacement towards the carina was calculated. Maximum tube tip displacements were plotted against age.

Results and Discussions: 28 children aged from 2 months to 16.5 years (median 7.4 years) were studied. Tube tip displacement ranged from 0–25% (14%) for 20° head tilt, 2–41% (16%) for capnoperitoneum and 11–70% (30%) for capnoperitoneum with 20° head tilt.

A-571
The optimal length of internal jugular venous catheters in children confirmed by TEE
S.Z. Yoon, Y.L. Kim, K.W. Yum, C.D. Park, B.M. Ham
Department of Anesthesiology, Seoul National University Hospital, Seoul, Republic of Korea

Background and Goal of Study: Incorrect positioning of central venous catheter (CVC) leads to serious complications. There have been several studies with regard to the optimal depth of CVC tip position to prevent serious complication in pediatric patients. However, the limitation of these study was that they used chest radiograph to determine the CVC tip position. The assessment of catheter tip position using chest radiograph is inaccurate. In contrast, transosophagal echocardiography (TEE) has been shown to accurately monitor the placement of catheter tip at superior vena cava-right atrial (SVC-RA) junction. We examined the distance from skin puncture
site to SVC-RA junction, after positioning the CVC tip at SVC-RA junction using TEE.

**Materials and Methods:** We studied 60 right internal jugular vein (IJV) catheterizations in infants and children undergoing surgery for congenital heart disease for 6 months. The position of CVC tip was confirmed that it is in SVC-RA junction by TEE. The distance from skin puncture site to SVC-RA junction, height, weight and age were recorded.

**Results and Discussions:** The measured distance highly correlated with the patient height. Based on these data, following guideline could be predicted that a CVC could be positioned above the RA 97.5% of the time with 95% accuracy. Optimal depth of insertion (cm) = 1.7 + (0.07 × height).

**Conclusion(s):** We suggest that using our simple practical guideline in the first attempt to insert the CVC could prevent malposition of CVC.

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**A-572**

**Filling cuff pressures in paediatric laryngeal mask airways**

P. Maino, A. Dullenkopf, C. Keller, V. Bernet, M. Weiss

Anaesthesia, University Children's Hospital, Zurich, Switzerland

**Background of Study:** Initial cuff volume at the time of LMA insertion may vary and considerable unknown high cuff pressure may result after inflation of maximum recommended cuff volumes increasing the risk of airway morbidity (1).

**Materials and Methods:** In an in vitro set up, maximum recommended cuff filling volumes for size 1/1.5/2/2.5/3 disposable LMAs from different manufacturers (Softseal LMA (Portex); Unique LMA (Intavent); Marshall LMA, LaryngoSeal (Tyco)) and reusable Classic and ProSeal LMAs (Intavent) were inflated into completely emptied LMA-cuffs and into LMA-cuffs at residual volume (volume with cuff set to ambient pressure). Cuff pressures were measured using a cuff manometer. Experiments were performed two times using two exemplars of each brand/size (4 measurements each).

**Results and Discussion:** (Data are mean ± SD)

<table>
<thead>
<tr>
<th>LMA/cuff pressures (cmH2O) after filling the completely emptied cuff with recommended volume of air</th>
<th>1</th>
<th>1.5</th>
<th>2</th>
<th>2.5</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Classic</td>
<td>71 ± 2</td>
<td>&gt;120</td>
<td>&gt;120</td>
<td>85 ± 5</td>
<td>97 ± 5</td>
</tr>
<tr>
<td>Unique</td>
<td>83 ± 1</td>
<td>&gt;120</td>
<td>&gt;120</td>
<td>&gt;120</td>
<td>&gt;120</td>
</tr>
<tr>
<td>ProSeal</td>
<td>78 ± 3</td>
<td>70 ± 3</td>
<td>42 ± 2</td>
<td>18 ± 2</td>
<td></td>
</tr>
<tr>
<td>SoftSeal</td>
<td>62 ± 1</td>
<td>53 ± 3</td>
<td>34 ± 3</td>
<td>70 ± 2</td>
<td>55 ± 2</td>
</tr>
<tr>
<td>Marshall</td>
<td>48 ± 1</td>
<td>91 ± 5</td>
<td>107 ± 2</td>
<td>97 ± 2</td>
<td>&gt;120</td>
</tr>
<tr>
<td>LaryngoSeal</td>
<td>&gt;120</td>
<td>&gt;120</td>
<td>&gt;120</td>
<td>&gt;120</td>
<td>&gt;120</td>
</tr>
</tbody>
</table>

Maximum recommended cuff filling volumes for paediatric LMAs inflated into fully emptied cuffs resulted in hyperinflation (cuff pressure >60 cmH2O) (2) in almost all LMAs. When maximum recommended cuff filling volumes were inflated into LMAs at residual cuff volume, cuff pressures of >120 cmH2O resulted in all LMAs and sizes except in the ProSeal size 3 (101 ± 1 cmH2O).

**Conclusions:** Maximum recommended cuff filling volumes in paediatric LMAs lead to cuff hyperinflation in almost all LMA brands and sizes. The cuffs should be inflated with the minimum volume of air required to form an effective seal with the respiratory and gastrointestinal tracts and cuff pressure should be controlled using a manometer to avoid cuff hyperinflation and associated airway morbidity.

**References:**


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**A-573**

**Tube tip displacement in children during head-neck movement – a radiological assessment**


Department of Anaesthesia, University Children’s Hospital, Zurich, Switzerland

**Background and Goal of Study:** Because of their short trachea appropriate tracheal tube insertion depth is mandatory in children to avoid inadvertent extubation or endobronchial intubation during head-neck movement. Aim of this study was to investigate appropriateness of insertion depth marks of the Microcuff paediatric tracheal tube (1) in children during head-neck movement.

**Materials and Methods:** With ERB approval and written parental consent we included children aged from birth to 16 years undergoing cardiac catheterisation. The patient’s trachea was orally intubated and the tubes positioned with the depth mark at the level of the vocal cords. The carina to tube tip distances were radiologically assessed with the patient supine and the head-neck in 30° flexion, 0° position and 30° extension. Percentual upward displacement of the tube tip related to tracheal tube insertion depth (depth mark distance) and downward movement related to carina – tube tip distance was calculated. Absolute tracheal tube tip displacements were plotted against age.

**Results and Discussions:** 60 children aged from 3 weeks to 15.7 years (median 5.4 years) were studied. Tube tip downward movement after head-neck flexion ranged from 5 to 58% (21%) of initial distance to carina and upward displacement after head-neck extension ranged from 5 to 38% (18%) of tube insertion depth.

**Conclusion:** The insertion depth marks were appropriate to avoid inadvertent tracheal extubation and endobronchial intubation during head neck movement in all patients.

**Reference:**


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**A-574**

**Effect of four mixtures on withdrawal movement during intravenous injection of rocuronium in pediatric patients**

S.M. Jung, P.S. Kang, H.U. Kwon, Y.S. Lim

Department of Anesthesiology, Konyang University Hospital, Daejeon, Republic of Korea

**Background and Goal of Study:** The purpose of this study was to evaluate the incidence and severity of withdrawal movement during injection of rocuronium mixed with saline, lidocaine, sodium bicarbonate (NaHCO3), lidocaine-NaHCO3 in pediatric patients.

**Materials and Methods:** Sixty-seven patients (5–15 years old) were randomly assigned to four groups in a double blinded, prospective study; Group S (0.9% normal saline 5 ml mixed with rocuronium 50 mg), Group L (2% lidocaine 5 ml mixed with rocuronium 50 mg), Group B (4% lidocaine 2.5 ml mixed with rocuronium 50 mg) and Group LB (4% lidocaine 2.5 ml and 8.4% NaHCO3 2.5 ml mixed with rocuronium 50 mg). All patients received intubating dose (0.6 mg/kg) of premixed rocuronium over 5 seconds after loss of consciousness with sevoflurane inhalation. We investigated the incidence and severity of withdrawal movement.

**Results and Discussions:**

**Table 1. Incidence and Severity of Withdrawal Movement.**

<table>
<thead>
<tr>
<th></th>
<th>Group S</th>
<th>Group L</th>
<th>Group B</th>
<th>Group LB</th>
</tr>
</thead>
<tbody>
<tr>
<td>(n = 19)</td>
<td>(n = 18)</td>
<td>(n = 14)</td>
<td>(n = 16)</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>9 (47.4%)</td>
<td>8 (44.4%)</td>
<td>12 (85.7%)</td>
<td>13 (81.3%)</td>
</tr>
<tr>
<td>Wrist</td>
<td>0 (0.0%)</td>
<td>1 (5.6%)</td>
<td>1 (7.1%)</td>
<td>2 (12.5%)</td>
</tr>
<tr>
<td>Arm only</td>
<td>2 (10.5%)</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Generalized</td>
<td>8 (42.1%)</td>
<td>9 (50.0%)</td>
<td>1 (7.1%)</td>
<td>1 (6.3%)</td>
</tr>
<tr>
<td>Overall Movement</td>
<td>10 (52.6%)</td>
<td>10 (55.6%)</td>
<td>2 (14.3%)</td>
<td>3</td>
</tr>
</tbody>
</table>

*p < 0.05 vs Group S; **p < 0.05 vs Group L.
Conclusion(s): We conclude that premixed NaHCO₃ with rocuronium is effective in reducing the withdrawal movement whereas addition of lidocaine is little effective in pediatric patients.

References:

A-575
Caudal block reduces demand of sevoflurane for adequate depth of anaesthesia in children
J.H. Song, T.J. Kim, C.S. Lee
Department of Anaesthesiology, Inha University Hospital, Incheon, Republic of Korea

Background and Goal: It is generally known that neuraxial anesthesia for adults reduces the demand for hypnotics needed for adequacy sedation. Therefore, this study examined the effect of a preoperative caudal block to the general anesthetic requirement on adequate depth of anesthesia in children.

Materials and Methods: Twenty children aged 3–5 in good health who were to undergo inguinal herniorrhaphy were divided into 2 groups of 10 children each, the control and caudal block groups. Under the condition of no premedication, tracheal intubation was performed after induction with thiopental 5 mg/kg, rocuronium 0.6 mg/kg, and sevoflurane 3.0 vol%. Subsequently, anesthesia was maintained with 100% O₂ and sevoflurane. After setting up the Bispectral Index (BIS) monitor, a caudal block was performed to both groups differently, normal saline 0.7 ml/kg was administered to the control group and 1.5% lidocaine 0.7 ml/kg was administered to caudal block group. A predetermined end-tidal concentration of sevoflurane was maintained for 10 minutes, and the BIS value, which measured 6 times every 10 seconds, was consequently averaged.

Afterwards, the end-tidal concentration of sevoflurane was increased by 0.2 vol% in the next patient if the BIS average of the precedent patient was 50, and was decreased 0.2 vol% if the BIS average was 50. The MAC₉₅ in both groups was calculated using probit analysis. The relative median potency analysis was applied to compare the results in both groups.

A-576
Usefulness of carina as a radiographic landmark of central venous catheter tip position in pediatric patients
Department of Anesthesiology, Seoul National University College of Medicine, Seoul, Republic of Korea

Background and Goal of Study: Several reports have proposed radiographic landmark of central venous catheter tip position. Carina is one of the proposed landmarks in adult. We evaluate the possibility of using the carina as a radiographic landmark for identifying the proper positioning of central catheter tip position in pediatric patients.

Materials and Methods: We studied 57 right internal jugular vein catheterizations in infants and children undergoing surgery for congenital heart disease. After placing the central venous catheter (CVC) tip at the junction of the superior vena cava and the right atrium (SVC-RA junction) using intraoperative transesophageal echocardiography and taking postoperative anterior-posterior chest radiographs, we measured the longitudinal distance from the carina to SVC-RA junction by using Picture Archiving and Communicating System (PACS).

Results and Discussions: We found that carina was 1.5 cm (95% confidence interval 1.3 cm–1.8 cm) above the SVC-RA junction. There was no catheter tip cephalad to carina. The distance is not correlated statistically with the patient age, height and weight.

Conclusion: The carina can be used as a landmark for the upper margin of the SVC in pediatric patients.

References:

A-577
Determination of the dose response relationship of spinal ropivacaine and levobupivacaine, combined with sufentanil, for labour analgesia
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Department of Anaesthesiology, UZLeuven and KULeuven, Leuven, Belgium

Background and Goal: Using the MLAC methodology, the relative potency of ropivacaine (R) and levobupivacaine (L) during labour analgesia is controversial (1,2,3). Full dose response curves of R and L during labour analgesia have not been constructed. The goal of the present study is to determine the full dose response curves of spinal R and L for labour analgesia.

Material and Methods: Following ethical committee approval and written patient informed consent, 300 term, vertex presenting pregnant patients in labour were included in this blinded, randomised trial. Combined spinal epidural analgesia was performed and R or L were intrathecally administered in a dose of 1.0, 1.5, 2.0, 2.5, 3.0 or 3.5 mg. In each group R or L were calculated in a dose of 1.0, 1.5, 2.0, 2.5, 3.0 or 3.5 mg. In each group R or L were combined with 1.5 μg sufentanil. Patients were considered responders if the visual analogue scale score for pain was less than 25 mm within 15 minutes after initiation of analgesia and if analgesia persisted for at least 45 min. Patient demographics, obstetrical data, side effects and foetal and neonatal well being were noted. Group specific dose response curves were constructed using a probit regression model. ED₅₀ and ED₉₀ doses were calculated for each group. A likelihood-ratio test has been used to compare the dose response curves of R and L.

Results and Discussion: No statistically significant differences in dose response relationship between R and L were observed (p = 0.91). The ED₅₀ of spinal R and L respectively was 2.213 mg (95% CI, 1.834–2.583) and 2.320 mg (95% CI, 2.054–2.617). The ED₉₀ of spinal R and L respectively was 4.791 mg (95% CI, 3.988–6.661) and 4.961 mg (95% CI, 4.106–6.950).

Conclusion: Based on the present full dose response study, intrathecal R and L combined with sufentanil, are of similar potency when used for labour analgesia. This is in line with more recent MLAC data by Polley et al and Benhamou et al. in which no ED₅₀ differences between epidural R and L were reported (4,5). These results contrast with previous findings based on direct MLAC comparisons of epidural R or L with bupivacaine (1,2,3).

References:

A-578
Incidence of neurological complications following regional anaesthesia in obstetrics
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Department of Anaesthesia, Leicester Royal Infirmary, Leicester, United Kingdom

Background and Goal of Study: For both parturients and anaesthetist one of the most feared complications of regional anaesthesia is a neurological deficit. The incidence has been reported as 0–30 per 10,000 blocks after epidural and 35 per 10,000 after spinal anaesthesia (1). The purpose of this retrospective study was to estimate the incidence of neurological complications following regional blockade in our unit.

Materials and Methods: All women who delivered from 1994 to 2003 had their postnatal anaesthetic/medical/clinic follow-up records retrospectively audited for lumbo-sacral spine and lower extremity nerve injury. Factors associated with documented nerve injury were noted: difficulty in insertion of regional block, pain or paraesthesia on insertion or injection, duration of second stage of labour, maternal position (i.e. lithotomy), instrumental delivery, fetal presentation and fetal compression of pelvic nerves.

Results and Discussions: 50,242 women delivered over the ten-year period (1994–2003), 23,029 (41.7%) received regional block. Total neurological
complications reported in association with pregnancy and delivery was 146. Detailed examination of the notes revealed only 43 of these women had a significant neurological complication and had a regional block. 12 women had spinal, 24 had epidural and 7 had combined spinal-epidural anaesthesia. Insertion was difficult in 3 and 2 patients had pain on injection of local anaesthetic. Other factors found to be associated with neurological injury were instrumented, seconed stage of labour and time spent pushing in lithotomy position. Duration of symptoms was less than three months in 32.2%, more than three in 34.8% and unknown in 37.2% (reasons were referral to other specialty clinics or patients not attending follow up clinic).

**Conclusion:** The estimated incidence of postpartum neurological complications associated with regional block in our unit is 0–20 per 10,000, but its definite relationship is yet to be proved.

**References:**

**A-579**

Epidural continuous infusion of sufentanil and neostigmine for labor analgesia

N. Renier, F. Roelants, V. Crispin, P.M. Lavandhomme
Department of Anaesthesiology, Cliniques Universitaires Saint-Luc, Brussels, Belgium

**Background and Goal:** During labor, motor impairment resulting from neuraxial local anesthetics leads to higher instrumental delivery rate and lower parturients’ satisfaction (1). Epidural neostigmine (N) 500 µg, a cholinesterase inhibitor, combined with sufentanil (S) initiates labor analgesia without motor block or side effects (2). The study compares the efficacy (analgesia, ropivacaine (R) consumption, instrumentation) of an epidural continuous infusion (CI) combining sufentanil with either ropivacaine or neostigmine during labor.

**Materials and Methods:** After informed consent, at the beginning of labor, a lumbar epidural catheter was inserted in healthy parturients. WhenVAS was >30/100, after a test dose, all patients receive epidural N 500 µg and S 10 µg in a total volume of 12 mL, then, were randomly allocated to receive epidural CI with S 2 µg/h and R 10 mg/h (group SR, n = 15) or S 2 µg/h and N 100 µg/h (group SN; n = 15) during 5 hours. After what R 0.1% was used until delivery. During CI, rescues doses of epidural R were available as needed. Pain scores, time before the 1st rescue dose (rescue 1) as well as number of rescues doses (n), labor duration, instrumentation rate and total R consumption were noticed. Maternal and fetal vital parameters and side effects were recorded.

**Results:** Parturients did not differ concerning demographic data. Analgesia efficiency (~ % parturients with VAS < 30/100) differed after 5 hours: SR 50% versus SN 17% (*) for similar cervical dilatation (6.75 vs 6 cm). Other results are expressed in the Table. Data are presented as mean ± SD and (95% CI). No particular side effects were observed.

<table>
<thead>
<tr>
<th>SR</th>
<th>SN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rescue 1 (min)</td>
<td>155 ± 74</td>
</tr>
<tr>
<td>n rescues</td>
<td>1.1 ± 1</td>
</tr>
<tr>
<td>L duration (min)</td>
<td>321 ± 164</td>
</tr>
<tr>
<td>R use (mg/h)</td>
<td>13.2 (10–15)</td>
</tr>
<tr>
<td>Instrumentation (%)</td>
<td>6.6</td>
</tr>
</tbody>
</table>

Statistical analysis used ANOVA: * p < 0.05 significant.

**Discussion and Conclusions:** Until cervical dilatation 6 cm, SN infusion provides similar analgesia to classical SR and allows R sparing effect. No particular side effects were observed.

**References:**

**A-581**

Ultrasound imaging of epidural anaesthesia for morbidly obese parturients

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Department of Anaesthetics, James Paget Hospital, Gorleston, United Kingdom

**Background and Objective:** Using ultrasound for the identification of the epidural space in obstetric patients has been reported1,2. With an increase in number of morbidly obese parturients (BMI > 40), we report our experience of the use of ultrasound for help in identification of the epidural space for epidural anaesthesia for labour pain control.

**Method:** All patients were given an explanation of the use of ultrasound and gave verbal consent. Patients (BMI > 40) lying in the left decubitus position were scanned with a 3.75-MHz curved array probe (Tosbee, TOSHIBA) placed in longitudinal plane immediately next to the midline of the back. The level of intervertebral space, L4/S, was confirmed and the distance measured from skin to the ligamentum flavum. The epidural needle was inserted, paramedian approach, from the marked place identified by the ultrasound and confirmed by loss of resistance to saline. 20 ml of 0.1% bupivacaine with fentanyl was given directly through the Tuohy needle with the epidural catheter inserted for the subsequent top-ups.

**Result:**

<table>
<thead>
<tr>
<th>Case</th>
<th>BMI</th>
<th>Palpation*</th>
<th>Distance**</th>
<th>Visability***</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>45</td>
<td>Poor</td>
<td>8.1</td>
<td>8</td>
</tr>
<tr>
<td>2</td>
<td>40</td>
<td>Slight</td>
<td>7.4</td>
<td>6.5</td>
</tr>
<tr>
<td>3</td>
<td>43</td>
<td>Slight</td>
<td>6.1</td>
<td>6.5</td>
</tr>
<tr>
<td>4</td>
<td>41</td>
<td>Slight</td>
<td>6.2</td>
<td>7</td>
</tr>
<tr>
<td>5</td>
<td>41</td>
<td>Poor</td>
<td>6.8</td>
<td>7.5</td>
</tr>
</tbody>
</table>

* Identification of intervertebral space.

** Distance from skin to epidural space (cm).

*** Visibility of ligamentum flavum.

There were no dural puncture and none of them took more than 5 min to scan for the epidural space.

**Conclusion:** Epidural anaesthesia was safely instituted for the morbidly obese patients using ultrasound guidance. There was reasonable agreement between depth of epidural space as predicted by ultrasound and that actually identified.

**References:**

**A-582**

Intravenous remifentanil versus epidural levobupivacaine with fentanyl for pain relief in early labour: a randomised, controlled, double blind study

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Department of Anaesthesia and Intensive Care, Lapland Central Hospital, Rovaniemi, Finland

**Background and Goal of Study:** Individually titrated intravenous patient controlled analgesia with remifentanil (RE) has been noted to provide...
Effect of pain relief during labour. We hypothesized that it could provide as satisfactory analgesia as epidural analgesia (EPID).

Material and Methods: After permission by ethics committee 52 healthy parturients with singleton uncomplicated pregnancies were randomised to receive either EPID with 20 ML levobuvicaine 0.625 mg/mL and fentanyl 2 µg/mL in saline or RE in a prospective, double-blind study. The PCA dose for RE was given over 1 min with a lockout time of 1 min. The dose was increased after every other uterine contraction starting from the bolus of 0.1 µg/kg up until individual effective dose was reached, until a maximum dose of 0.9 µg/kg was reached, or 60 minutes had elapsed. The parturient's assessment of contraction pain (verbal numerical score 0–10), pain relief (rank categorical score 0–4), sedation and nausea (rank categorical scores 0–3) were recorded at 10 minutes averages. Averages of the scores were calculated for each patient. Mann-Whitney and chi square tests were used for statistical analyses. P < 0.05 was considered significant. Data are median with 25th and 75th percentiles.

Results: 46 parturients were included in the analysis. Mean age was 28 years. Cervical opening was 4 cm (3–5) before the study and 7 cm (5–9) after the study. The pain scores were 7.3 (5.6–8.2) and 5.6 (2.2–6.7) during RE and EPID, respectively (p < 0.009). The pain relief scores were 2.5 (2.2–2.9) and 2.8 (2.0–3.5) for RE and EPID, respectively (p = 0.17). Sedation scores were 2.3 (1.3–2.6) and 0 (0–0.8) with RE and EPID, respectively (p < 0.001). All parturients remained responsive and able to discuss throughout the study. Already before RE, 9 parturients had nausea. This continued during the study period albeit milder. 2 parturients started to have mild nausea during EPID.

Conclusions: In terms of pain scores EPID is superior to RE. However, there was little difference in the pain relief scores between the treatments. With RE, sedation was an obvious side effect. RE did not increase the number of parturients who had nausea.

Reference:

A-583
Ephedrine and phenylephrine for maternal hypotension in a chronic sheep model with increased placental vascular resistance
Department of Anaesthesiology, University hospital of Oulu, Oulu (OYS), Finland

Background and Goal of Study: We studied the effects of ephedrine and phenylephrine on uterine and placental circulations and fetal acid-base status and lactate levels in a chronic sheep model with increased placental vascular resistance (RU) induced by placental embolization.

Materials and Methods: At 115–136 days’ gestation, chronically instrumented, anesthetized ewes with placental embolization were randomized to receive boluses of ephedrine or phenylephrine for maternal epidural-induced hypotension. Uterine (QUUT) and placental (QPL) volume blood flows were measured with perivascular transit-time ultrasonic flow probes, and uterine vascular resistance (RU) and RU were computed from volume blood flows and maternal and fetal mean arterial pressures (MAPs). Statistical analysis: ANOVA, followed by paired t-test.

Results and Discussion: During hypotension, maternal MAP and HR, QUUT, RUA, and fetal pH and PO2 decreased and RU and fetal lactate increased. Following treatment, fetal pH did not further decrease in either group, but fetal lactate increased in the phenylephrine group (mean difference 1.5, 95% confidence interval 0.7 to 2.3 mmol/l) [1], P = 0.004.

Table 1.

<table>
<thead>
<tr>
<th></th>
<th>Ephedrine (n = 7)</th>
<th>Phenylephrine (n = 6)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline</td>
<td>Baseline</td>
</tr>
<tr>
<td></td>
<td>Vasopressor</td>
<td>Vasopressor</td>
</tr>
<tr>
<td></td>
<td>P</td>
<td>P</td>
</tr>
<tr>
<td>MAP (mmHg)</td>
<td>92 ± 10</td>
<td>88 ± 10</td>
</tr>
<tr>
<td>HR (b/min)</td>
<td>130 ± 17</td>
<td>152 ± 20</td>
</tr>
<tr>
<td>QU (l/min)</td>
<td>576 ± 221</td>
<td>532 ± 199</td>
</tr>
<tr>
<td>RUA</td>
<td>0.9 ± 0.06</td>
<td>0.19 ± 0.10</td>
</tr>
<tr>
<td>QPL (l/min)</td>
<td>49 ± 7</td>
<td>53 ± 9</td>
</tr>
<tr>
<td>R (l/min)</td>
<td>182 ± 24</td>
<td>169 ± 44</td>
</tr>
<tr>
<td>pH</td>
<td>3.0 ± 1.1</td>
<td>2.7 ± 0.10</td>
</tr>
<tr>
<td>PO2</td>
<td>7.0 ± 0.6</td>
<td>7.3 ± 1.4</td>
</tr>
<tr>
<td>Lactate</td>
<td>2.1 ± 0.5</td>
<td>2.4 ± 0.5</td>
</tr>
</tbody>
</table>

Values are mean ± SD. *P < 0.05 compared with baseline.

Discussion: In a previous study [1] we demonstrated an analgesic potency hierarchy of intrathecal bupivacaine > levobupivacaine > ropivacaine. The results of our study suggest the parallel nature of the analgesic and motor responses of intrathecal picoxycloiodines.

Reference:

A-584
The relative motor blocking potencies of intrathecal bupivacaine, ropivacaine and levobupivacaine
C. Berrietta, M. Camorcia, G. Capogna, M.O. Columb
Department of Anesthesiology, Città di Roma Hospital, Roma, Italy

Introduction: We determined the ED50 motor block for intrathecal bupivacaine (B), ropivacaine (R) and levobupivacaine (L).

Method: After local ethic committee approval and informed consent, 99 women, at term, undergoing elective Caesarean section under combined spinal-epidural anaesthesia were randomised to receive spinal 0.5%, B, R or L. The starting dose was 4 mg and the testing interval 1 mg. Subsequent doses were determined by the response of the previous parturient according to the up-down sequential allocation. The end point was the occurrence of any motor block (Bromage and hip motor function scale) within 5 minutes. The sequences were analysed using up-down and probit regression to estimate ED50 with 95% confidence interval (CI) and then compared using one-way ANOVA with Tukey post-tests. Significance was defined at P < 0.05 (two-sided).

Results: The ED50s for motor block are reported in the Table (ANOVA: P < 0.0007). The potency ratios were: R:B 0.59, L:B 0.71 and R:L 0.83.

<table>
<thead>
<tr>
<th></th>
<th>ED50 (µg)</th>
<th>95%CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ropivacaine</td>
<td>5.79</td>
<td>4.82–6.96</td>
</tr>
<tr>
<td>Levobupivacaine</td>
<td>4.83</td>
<td>4.35–5.32</td>
</tr>
<tr>
<td>Bupivacaine</td>
<td>3.44</td>
<td>2.55–4.34</td>
</tr>
</tbody>
</table>

Discussion: Despite the more favorable effects on uterine and placental circulations of ephedrine over phenylephrine, we observed no significant differences in fetal acid-base status. Fetal lactate, however, increased further from hypotensive values with phenylephrine but not with ephedrine.

A-585
The influence of intravenous PCA remifentanil infusion and PCA continuous epidural analgesia on cortisol and IL-6 levels in primiparas anaesthetised for delivery
J. Sokół-Pastuszka, A. Makowski, S. Kempinski, M. Blach, K. Safranow, R. Bohatyrziewicz
Anaesthesiology and Intensive Care, Pomeranian Medical University; Szczecin, Poland

Background and Goal of Study: Delivery is a stressful and painful event which can modify IL-6 and Cortisol levels. Although various kinds of anaesthesia techniques for delivery were tested, so far, only epidural PCA has become the “golden standard”. Patient controlled intravenous infusion of Remifentanil, a new short acting opioid, seems to be a valuable alternative treatment for the future. We estimated the influence of both kinds of PCA for delivery on IL6 and Cortisol concentrations.

Materials and Methods: After obtaining written consent we divided 18 healthy, ASA I/II primiparas into two equal groups. Group RF parturients were anaesthetised with PCA remifentanil intravenous infusion (concentration 10 µg/mL, PCA bolus 0.2 µg/kg, lockout time 2 minutes, no base flow). Group E – patients received epidurally bolus of 8 ml 0.125% bupivacaine with 0.1 mg Fentanyl. Anaesthesia was continued with 0.125% bupivacaine (PCA bolus 4 ml, lockout time 15 min, base flow 1 ml/hour). We recorded:

1. duration of first and second delivery stage,
2. mean VAS score,
3. IL-6 level before anaesthesia (IL6 I) and after delivery (IL6 II),
4. mean maternal blood cortisol levels.

The data was analysed with U-Mann-Whitney test.
Results: There was no difference between both groups inVAS score and the first stage of delivery duration. The second stage of delivery was significantly longer in the E group.

Data of IL-6 and Cortisol are shown as mean ± SD in the Table.

<table>
<thead>
<tr>
<th>IL-6 (µg/dl)</th>
<th>Cortisol (µg/ml)</th>
</tr>
</thead>
<tbody>
<tr>
<td>E: 6.98 ± 7.22</td>
<td>Rf: 10.93 ± 40.79</td>
</tr>
<tr>
<td>8.48 ± 5.14</td>
<td>49.39 ± 20.70</td>
</tr>
</tbody>
</table>

Conclusion: Intravenous PCA Remifentanil infusion and PCA continuous epidural analgesia do not create differences in IL-6 and Cortisol concentrations in primiparous anaesthetised for delivery.

A-586
Impact of artificial rupture of membranes on provision of anaesthetic services – could the bubble burst?

J. Dolan, J. Morrison, C. Greashalgh
Department of Anaesthesia, Royal Infirmary, Glasgow, United Kingdom

Background and Goal of Study: Much obstetric workload is unplanned. However, one area of practice which can be controlled is the induction of labour in general and artificial rupture of membranes (ARM) in particular. Given the paucity of data regarding the impact of ARM on anaesthetic workload a retrospective study was undertaken to investigate the frequency as well as timing of ARM and to correlate these aspects with the provision of epidural anaesthesia.

Materials and Methods: A retrospective audit of 1131 patients admitted to a city maternity hospital over a 3 month period was undertaken. Elective Caesarean sections were not included. Data were analysed using descriptive statistics (Chi-squared test).

Results and Discussions: The number of women requiring ARM was 157 (14%). Only 10% of women who had ARM delivered between 0900 h and 1300 h with the peak delivery times of 1900 h and 0100 h. 20% with an ARM presented for emergency Caesarean section and 53% over a week. Patients having ARM after 1500 h are statistically more likely to deliver between midnight and 0900 h (p < 0.001).

Conclusion(s): ARM influences the timing and mode of delivery. This in turn has an impact on out-of-hours obstetric and anaesthetic workload, irrespective of the weekday. Because of the European Working Time Directive and the increasing out-of-hours workload which is now placed on the consultant workforce, morning ARM should be considered to minimise disruption of subsequent elective work.

A-587
Maternal and neonatal effects and placental transfer of remifentanil given at induction of general anaesthesia for Caesarean section: a randomized double-blinded controlled trial

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Department of Anaesthesia and Intensive Care, The Chinese University of Hong Kong, Shatin, China

Background and Goal of Study: Although case reports have described the use of remifentanil to improve haemodynamic stability during general anaesthesia for Caesarean section (CS) in patients with coexisting disease, there has been no controlled study of its use. Our aim was to compare the maternal and neonatal effects of a single bolus of remifentanil 1 mcg/kg given at induction and to quantify the placental transfer of remifentanil.

Materials and Methods: With Ethics approval and written consent, in a double-blind study, we randomized patients having general anaesthesia for CS to receive i.v remifentanil 1 mcg/kg (Group 1, n = 20) or saline (Group 0, n = 20) over 30s before thiopental/succinylcholine. Maintenance was with isoflurane in N2O/O2. We compared maternal haemodynamic changes and neonatal condition at birth. We measured maternal and umbilical plasma levels of remifentanil using liquid chromatography-tandem mass spectrometry. Data were analyzed with t-test, Mann-Whitney, Chi-square and ANOVA-RM.

Results and Discussions: Serial changes in maternal blood pressure (BP) and heart rate (HR) until delivery were lower in Gp 1 vs Gp 0 (P < 0.001). Maximum values (mean ± SD) were lower in Gp 1 vs Gp 0 for systolic BP (127 ± 12.6 vs 165 ± 23.0, P < 0.0001), mean BP (98 ± 8.6 vs 123 ± 15.9, P < 0.0001) and HR (112 ± 5.4 vs 126 ± 15.4, P = 0.0008). Apgar score, cord gases and time to sustained respiration were similar between groups. However, two neonates in Gp 1 were considered clinically depressed and received naloxone. Remifentanil crossed the placenta with umbilical venous/maternal arterial ratio 0.73 ± 0.17 and umbilical arterial/umbilical venous ratio 0.60 ± 0.23.

Conclusion(s): Single bolus i.v. remifentanil 1 µg/kg effectively attenuated haemodynamic changes after induction and tracheal intubation. However, remifentanil crosses the placenta and may cause neonatal depression and should be reserved for clear maternal indications when adequate facilities for neonatal resuscitation are available.

Reference:

A-588
Levobupivacaine versus racemic bupivacaine in spinal anaesthesia for Cesarean section

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Background and Goal of Study: Racemic bupivacaine is the most common local anaesthetic used intrathecally. This study aimed to detect if intrathecal (i.t.) levobupivacaine and bupivacaine provided anesthesia (satisfactory analgesia and muscle relaxation) and postoperative analgesia in patients undergoing Cesarean section.

Materials and Methods: Sixty parturients were enrolled. Patients were assigned to receive one of the following i.t. solutions: levobupivacaine 0.5% 15 mg (n = 30) and bupivacaine 0.5% 15 mg (n = 30) at L3-4. Anesthesia was considered effective if an upper sensory level of T4 (verified with pinprick test) was achieved; motor blockade was documented by using modified Bromage score. Hemodynamic variables (e.g. blood pressure, heart rate, pulse oxymetry) were recorded every minute for the first 10 min. after the i.t. injection; then – every five minutes.

Results and Discussions: Intergroup differences between levobupivacaine and bupivacaine were insignificant both with regard to the onset of time and duration of sensory and motor blockade (10 ± 3 versus 12 ± 4 min; 9 ± 3 versus 11 ± 3; 238 ± 67 versus 247 ± 75; 290 ± 78 versus 295 ± 82). Both groups showed slight reduction in heart rate and mean arterial pressure, but there were no intergroup differences in hemodynamics. Patient satisfaction was good in all cases.

Conclusions: Levobupivacaine, the pure (S)-(-)-enantiomer of racemic bupivacaine, is an equally effective local anesthetic for spinal anesthesia for Cesarean section, compared with racemic bupivacaine.

A-589
Thromboelastography to predict the safe removal of epidural catheters following elective Caesarean section

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Background and Goal of Study: The use of heparin thromboprophylaxis following elective Caesarean section (CS) is becoming increasingly common (1). It is also common practice to administer rectal diclofenac at the end of surgery (2), raising the question of the optimum time for safe removal of epidural catheters when CS is performed under a regional anaesthetic technique. Thromboelastography (TEG) has proved useful in assessment of perioperative coagulation following major surgery (3).

Materials and Methods: We studied 24 pregnant women, of moderate thromboembolic risk, presenting for elective CS. Citrated blood was collected at (i) before regional block (ii) at termination of surgery, but before unfractionated heparin (5000 units subcutaneously) and rectal diclofenac (100 mg) and (iii) at 4 hours post-operatively. The samples were studied using TEG, with reference to time to a specific clot strength (R) and maximum clot strength (M).
A-596
UK vs US partner anxiety prior to elective Caesarean section under regional anaesthesia
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Background and Goal of Study: We compared and contrasted measured anxiety levels in partners of women undergoing elective Caesarean section with regional anaesthesia. Our aim was to discover an international variation in partner anxiety response. Over 90% of elective Caesarean sections at the Princess Margaret Hospital, Swindon, UK [1] and the University of Michigan Hospital, US [2] are performed under regional anaesthesia.

Materials and Methods: 91 UK and 100 US partners of women undergoing an elective Caesarean section with regional anaesthesia were recruited. The questionnaire used in the UK and US, comprised 4 parts: (1) Demographic data i.e. age, gender, occupation, education, previous attendance at Caesarean sections, attendance at anaesthetic clinics and relationship to patient; (2) Leeds Self Assessment of Anxiety (SAA) scale [3]; (3) Specific questions about source of anxiety; 4 Specific questions about relieving factors of anxiety. Additional comments were invited from the partners for the final 2 sec-

Results and Discussions: Patients did not differ concerning demographic data, sensory level, time before baby delivery and Aggar scores. % patients needing vasopressors at different time (T in min post SA) and total vaso-

References:

A-592
Prophylaxis of perioperative nausea and vomiting with subhypnotic dose of propofol and dexamethasone during intradural anaesthesia in cesarean section
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Background and Goal of Study: To determine the preventive and thera-

Materials and Methods: Controlled, randomized double blind study of 60 women (ASA I-II) receiving intradural anaesthesia for elective cesarean sec-

Results and Discussions: Groups were comparable with respect to demo-

Conclusion(s): These UK/US partner anxiety findings warrant further investiga-

Results: Twenty eight percent of partners in both the UK and US study demonstrated anxiety scores comparable with a pathological state.

Conclusion: These UK/US partner anxiety findings warrant further investiga-

References:

A-591
Comparison of ephedrine-phenylephrine vs ephedrine to treat hypotension during elective cesarean section after spinal anesthesia
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Background and Goal of Study: Recent studies suggest that preventive administration of phenylephrine (P) combined with ephedrine (E) halved the incidence of hypotension during cesarean section (CS) under spinal anesthesia (SA). This study assesses the effectiveness of curative administration of E + P mixture by comparison with E alone to treat hypotension during SA for CS.

Materials and Methods: After informed consent, 40 healthy parturients scheduled for elective CS received a crystalloid preload of 15 ml/kg. SA (8 mg hyperbaric bupivacaine, 2 μg sufentanil) was performed in the sitting position. Hypotension (SBP < 100 mmHg or decrease < 20% baseline) was treated with 1 ml incremental bolus doses of vasopressor (V) solutions. Parturients were randomly allocated into 2 groups and receive either E-P mixture containing E 3 mg/mL with P 15 μg/ml (group E-P; n = 20) or E with a concentration of 3 mg/ml (group E; n = 20). Maternal blood pressure and heart rate at different time points after spinal injection as well as V administration needed to avoid hypotension were recorded. Data are expressed as mean ± SD. Statistical analysis used ANOVA; p < 0.05 was considered significant.

Results and Discussions: Patients did not differ concerning demographic data, sensory level, time before baby delivery and Aggar scores. % patients needing vasopressors at different time (T in min post SA) and total vaso-

Conclusion(s): E + P combination reduces total amount of vasopressors

References:
A-593
Intrathecal ropivacaine for caesarean section – a dose-finding study
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Background and Goal of Study: Ropivacaine, a relatively new aminoamide local anaesthetic, has recently been licensed for intrathecal application for various indications. There is however no official recommendation of any dosage regimen to be used in women undergoing caesarean section. We reviewed all caesarean sections done in our department using ropivacaine in different dosages.

Materials and Methods: 40 women undergoing elective caesarean section received the following doses of spinal ropivacaine: 10 mg ± 0.1 mg morphine, 12.5 ± 0.1 mg morphine, 12.5 mg or 15 mg of spinal ropivacaine.

Patients did not receive any fluid preload. The level and duration of sensory block, intensity and duration of motor block using a modified Bromage score, time to mobilize and changes in mean arterial pressure were recorded at timed intervals.

Results and Discussions: 10 mg ± 0.1 mg morphine was only used in two patients since it provided insufficient sensory and motor block. 15 mg of spinal ropivacaine produced sensory block at T3/4 level; 12.5 mg produced sufficient sensory block at T6/7 level but with a short duration of 72 ± 7 min until complete void of the block.

Conclusions: Low-dose ropivacaine is safe and easy to use in women undergoing caesarean section since it provides sufficient analgesia and motor block and haemodynamic depression is rare. Some dose-finding studies could not see any advantages of ropivacaine over other local anaesthetics but doses of ropivacaine used in those studies were much higher. Comparative studies between low-dose ropivacaine and other local anaesthetics used in women undergoing caesarean section are necessary.


A-594
Serum leptin, cortisol and malondialdehyde levels for evaluation of surgical stress response in general and spinal anesthesia
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Introduction and Objective: The importance of stress hormones for evaluation of surgical stress response was well known. In this study, we aimed to investigate the effects of general and spinal anesthesia on stress response in vaginal hysterectomy operations.

Materials and Methods: After approval of faculty ethics committee, 40 patients (ASA I-II) scheduled for vaginal hysterectomy were included in the study. They were divided into two groups randomly. Group I patients (n = 20) were operated under general anesthesia and spinal anesthesia was used for group II patients (n = 20). Anesthesia was induced with tiopental sodium (5 mg/kg, I.V.) and vecuronium bromur (0.1 mg kg, I.V) and maintained with 50% N2O + 50% O2 and 2% sevoflurane in Group I. Group II patients received bupivacaine and fentanyl via a 22 gauge spinal needle placed between L3–4 level. Blood samples were collected for preoperative (1), Perioperative (2) and postoperative (3) analysis of serum leptin, cortisol and malondialdehyde levels. The results were compared by using t-test and repeated measures analysis.

Results: Serum leptin and MDA levels showed no difference between two groups for all sampling periods. However, serum cortisol levels of 3rd period were detected higher in group I (711 ± 206) than group II (481 ± 186).

No difference was determined between two groups with respect to serum levels of leptin in all sampling periods. MDA levels increased postoperatively (1.66 ± 0.6) compared to preoperative values (1.33 ± 0.5) in group I, whereas no difference was observed in Group II.

Conclusions: We believe that differences between two groups with respect to serum cortisol and MDA levels show that spinal anesthesia is more useful than general anesthesia to prevent surgical stress response.

A-596
Percutaneous dilatational tracheostomy in 139 critically ill patients: evaluation of our experience
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Background and Goal of Study: A number of percutaneous procedures for tracheostomy (PDT) have been established within the last few years. Three techniques for percutaneous tracheostomy – the established Translaringeal Fantoni technique (TLT), a variant to TLT and the new Percutiwist were prospectively studied for perioperative and postoperative complications in 139 critically ill patients.

Materials and Methods: During an eight years period we performed 139 PDT (age 74 ± 8 yrs), 27 classic TLT, 9 percutiwist and 103 TLT modified (without rigid tracheoscopy): infection of the tracheostomy site and severe coagulopathy were considered contraindications for tracheostomy. In all (without rigid tracheoscopy): infection of the tracheostoma and severe coagulopathy were considered contraindications for tracheostomy. In all patients (mean age 56 ± 32 yrs) 27 classic TLT, 9 percutiwist and 103 TLT modified (without rigid tracheoscopy): infection of the tracheostoma and severe coagulopathy were considered contraindications for tracheostomy. In all patients (mean age 56 ± 32 yrs) were studied. A lung CT scan was performed in static conditions during an end expiratory pause at 5 cm H2O of PEEP (140 mA, 120 Kv). The lung was manually drawn and the quantitative analysis to assess the volume–weight of the lung was made using dedicated software (Softefilm, University of Milan, Italy).

Results and Discussions: There was no relationship between the ideal body weight and the degree of lung inflation during controlled mechanical ventilation.

Materials and Methods: 34 intubated, sedated and paralyzed ALI/ARDS patients (mean age 56 ± 18 years, body mass index 23.7 ± 3.6 Kg/m2, PaO2/FiO2 194 ± 79 mmHg; PEEP 11.1 ± 2.7 cmH2O; tidal volume 575 ± 148 ml resulting in a tidal volume per body weight of 8.5 ± 1.6 ml/kg) were studied. A lung CT scan was performed in static conditions during an end expiratory pause at 5 cm H2O of PEEP (140 mA, 120 Kv). The lung was manually drawn and the quantitative analysis to assess the volume–weight of the lung was made using dedicated software (Softefilm, University of Milan, Italy).

Results and Discussions: There was no relationship between the ideal body weight and the inflated lung volume (p = 0.085, r = 0.033). Identical results were obtained also considering the lung weight.

We did not find any relationship between the ideal body weight and the inflated lung volumes, thus when setting the tidal volume based on body weight it does not reflect the “real” lung inflation.
A-598
The effect of midazolam on the oleic acid induced acute lung injury in rats
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Background and Goal of Study: Although some of the other commonly used intravenous anaesthetics have been shown to be protective in acute lung injury (1), the effects of midazolam on the acute lung injury is not known. We aimed to investigate the effects of midazolam in oleic acid-induced acute lung injury in rats.

Materials and Methods: 30 male Wistar rats were randomly allocated into 5 groups. Control group (n = 6), Vehicle group (n = 5) (the dissolving chemicals of midazolam in its pharmaceutical formula), Midazolam group (n = 7), Oleic acid (50 mg/kg i.p.), Oleic acid + midazolam group (n = 6) (50 µl Oleic acid i.v.) and Oleic acid + midazolam group (n = 6; 50 µl Oleic acid i.v. + midazolam (50 mg/kg)). A histologist who was blinded to the animals’ group assignment assessed the acute lung injury (interstitial oedema, alveolar haemorrhage, intraalveolar neutrophils, intraalveolar macrophages and intraalveolar pneumocytes, total lung injury). Kruskal Wallis and Mann-Whitney-U tests were used. p < 0.001 was considered as significant for pairwise comparisons.

Results and Discussions: Midazolam increased the interstitial oedema (median [95%CI] score: 2[0–3]) compared to the control group (0[0–0]) and to the vehicle group (0[0–1]). Oleic acid caused significant total lung injury (9.5[4–12]) compared to the control group (1[0–3]) and to the vehicle group (1[0–2]). There were no differences between the oleic acid group (9.5[4–12]) and the oleic acid + midazolam group (8[3–13]) regarding the severity of the acute lung injury.

Conclusion(s): We found that oleic acid caused significant acute lung injury and midazolam failed to attenuate this damage. The potential clinical implication of this study is the safety of using midazolam for induction in patients with acute lung injury, although it is not protective.

Reference:

A-600
Broncho-alveolar lavage in critically ill patients in the intensive care unit
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Background and Goal of Study: Respiratory infections and the development of resistant strains are one of the major problems in the ICU. The objective of the study was to identify the bacteria most frequently isolated by broncho-alveolar aspiration and the kind of antibiotics they were resistant to.

Materials and Methods: Prospective study included 128 patients, aged from 23–61 years. Group I consisted of polytraumatized cases, while group II included operated patients (ileus, pancreatitis, perforations, peritonitis, etc.). On day 3rd and 10th from the admission to the ICU, bronchoalveolar aspirates were collected from all patients and analyzed in microbiological laboratory with appropriate drug susceptibility test for prescription of target antibiotic therapy. All patients were scored according to APACHE II scoring system.

Results and Discussions: The results obtained by the first and the second bronchoalveolar lavage are as follows. The analysis of the first result reveals that the highest percentage of Staphylococcus aureus and Xanthomonas was found in group I of patients, while Staph. aureus, Xanthomonas and Acinobacter spp. were most prevalent in group II. The increased proportion of Pseudomonas spp. in the second sample was reported in both groups of patients, what could be explained by development of resistant strains to potent antibiotics (Meningen, Mepenem). In case of use of these antibiotics sensitivity, intermediate sensitivity and resistance were similar: 89.9%, 2%, 9.1%, and 91.9%, 0.9%, and 7.2% respectively. Sensitivity to Vancomycin was 100% in case of Staphy, aureus infection.

Conclusion(s): Therefore, it is necessary to take a critical view of antibiotic application, because the resistance to potent antibiotics might seriously question the control of infection.

A-601
Aquired tracheoesophageal fistulas in critically ill patients
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Background and Goal of Study: Acquired tracheoesophageal fistulae (TEF) represents the life-threatening complication of prolonged mechanical ventilation in critically ill patients. The management of patients with acquired TEF is controversial.

Materials and Methods: Between January 2001 and July 2004, a total of 1450 patients were admitted to surgical ICU requiring mechanical ventilation. Study population comprised trauma patients with multiple injuries and surgical patients with acute surgical abdomen. Seventy patients (4.8%), two women and five men with median age of 37 (21–54) years had tracheoesophageal fistula resulting from median 51 (range 22–98) days of tracheal intubations. Six were cuff related decubital tracheal injuries, and one appeared accidentally during inserting the tracheostomy tube. Diagnosis was made by oesophagography. The median TEF length was 2.5 ± 1.2 cm and defects were associated with tracheal stenosis.

Results and Discussions: Immediate treatment was supportive, adequate nutrition was facilitated by inserting jejunostomy. Three patients were weaned from mechanical ventilation. Two of them had recurrent sepsis episodes and persistent pulmonary infection. In one patient, after establishing spontaneous breathing, radical surgical repair of the trachea was performed. The patient successfully recovered. In the second case, the airway defect was closed using extrathoracic muscle flap. Two patient died in early postoperative period. There was no spontaneous closure of the fistula. All other patients died.

Conclusion(s): Our experience suggests that TEF is still the life-treating complication of prolonged mechanical ventilation in critically ill patients. Surgical correction is required because spontaneous closure of the fistula is rare.

A-602
Experimental comparison of Ciaglia and Griggs PCT techniques with biomechanical method
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Background and Goal of Study: To create a method for biomechanical experimental evaluation of percutaneous tracheostomy (PCT). Nowadays two techniques of PCT (Ciaglia and Griggs) are employed. Every technique is based on gradual tearing of the hole in the cervical trachea by specially designed dilators. Biomechanical study of the different stages of PCT will help to compare the course of these two techniques.

Materials and Methods: PCT by Ciaglia technique (n = 10) and by Griggs technique (n = 10) were performed on fresh dead pigs with mass of the body 115 ± 3kg. Portex set of instruments was used for Griggs technique and Cook set of instruments – for Ciaglia technique. During different stages of PCT (piercing, penetrating, pulling, and pushing) special measurements of forces were applied on different instruments were performed with the help of electronic dynamometer (MRC). Calculations of energy spent for these stages of PCT were done. At the end of experiments evaluation of the cervical trachea was performed to receive objective parameters of each tracheotomy.

Results and Discussions: Application of Ciaglia dilator requested more energy (1.54 times) than Griggs dilating forceps (p < 0.05). Formation of tracheostomy by Ciaglia dilator was more exact than by Griggs forceps due to special markings on the dilator. The work with Griggs dilating forceps requested additional experience due to absence of any markings on the dilator. Laceration of the cervical trachea could be easily happened in the time of work with dilating forceps in Griggs technique and during insertion of tracheostomy tube loaded on dilator in Ciaglia technique. Macroscopic appearance and parameters of each tracheostomy type were the same (p < 0.05).

Conclusion(s): PCT by these two techniques has almost similar biomechanical characteristics. In spite of difference in the design of dilators the final result of the two techniques is the same. Both techniques have some
A-603
Effectiveness of continuous positive airway pressure (CPAP) face mask Boussignac-Vygon as a treatment of acute respiratory failure

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Background and Goal of Study: Among different types of non-invasive mechanical ventilation, in recent years a face CPAP mask (Boussignac-Vygon) has been developed and used in a mode of CPAP ventilation. An O2 supply is used to create through a special valve mechanism continuous positive pressure in the airways; the aim of our study was to evaluate the effectiveness of CPAP Boussignac system as treatment of acute respiratory failure in ICU patients.

Material and Methods: We have studied all patients with acute respiratory failure treated with CPAP Boussignac during a four years period. In all patients CPAP was applied at a setting of 5–7 cm H2O. Main variables were demographical data, SAPS value, etiology of respiratory failure, length of treatment and its complications, changes in arterial blood gases and clinical data.

Results and Discussion: 20 patients were enrolled; 17 patients (85%) were men and 3 (15%) were women. Mean age was 54.8 yr (± 24.35) with a range from 22 to 85 yr; 9 patients were postoperative ones and 11 were traumatic. Etiology of acute respiratory failure was: 7 patients (35%) with atelectasis, 2 (10%) with pleural effusion, 2 (10%) with pneumonia, 1 (5%) with acute cardiogenic pulmonary edema and 8 patients (40%) with thoracic trauma. Mean SAPS was 29(±11); mean CPAP treatment length was 32.95 hours (±24.35) with a range from 3 to 101 hours. Intubation was necessary in 3 cases (15%).

Blood arterial gases results and clinic evolution

<table>
<thead>
<tr>
<th></th>
<th>Before CPAP</th>
<th>After CPAP</th>
</tr>
</thead>
<tbody>
<tr>
<td>pH</td>
<td>7.4 ± 0.06</td>
<td>7.41 ± 0.03</td>
</tr>
<tr>
<td>pCO2 (mmHg)</td>
<td>43 ± 7.1</td>
<td>43 ± 5.0</td>
</tr>
<tr>
<td>PaCO2 (mmHg)</td>
<td>196 ± 68</td>
<td>258 ± 80</td>
</tr>
<tr>
<td>SATO2 (%)</td>
<td>95 ± 2.9</td>
<td>98 ± 1.8</td>
</tr>
<tr>
<td>Respiratory rate (%)</td>
<td>21 ± 4</td>
<td>19 ± 3</td>
</tr>
<tr>
<td>Heart rate</td>
<td>92 ± 28</td>
<td>87 ± 21</td>
</tr>
</tbody>
</table>

Mean ± SD; *p < 0.05 t-student.

Conclusions: CPAP-Boussignac system is a respiratory support that is easy to use, it is well tolerated and has a low cost and it could avoid intubation in certain conditions. In our study it has been useful in 85% of patients with and improvement of FiO2/pO2 and SatO2 parameters after treatment.

A-604
Weaning from mechanical ventilation in patients with intra-abdominal hypertension

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Background and Goals: Intra-abdominal hypertension (IAH) is frequent in ICU [1] and it may adversely affect respiratory function. The aim of our study was to assess the correlation between intra-abdominal pressure (IAP) and P0.1, as a conditioning factor of successful weaning.

Materials and Methods: 5 patients with IAH (IAP > 15 cmH2O) and 5 patients with no IAH, during weaning from mechanical ventilation, were studied. IAP was measured by the bladder pressure method; Pes and P0.1 were recorded by Bicore CP-100 Pulmonary monitor.

Results: Data are shown in table 1:

Table 1.

<table>
<thead>
<tr>
<th>Pz</th>
<th>IAP*</th>
<th>P0.1*</th>
<th>Pes*</th>
<th>f/Vt</th>
<th>PaO2/FiO2</th>
<th>Weaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4.08</td>
<td>4</td>
<td>6</td>
<td>40</td>
<td>220</td>
<td>Failed</td>
</tr>
<tr>
<td>2</td>
<td>4.08</td>
<td>4</td>
<td>9</td>
<td>13</td>
<td>258</td>
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<tr>
<td>3</td>
<td>6.8</td>
<td>4</td>
<td>10</td>
<td>16</td>
<td>140</td>
<td>&quot;</td>
</tr>
<tr>
<td>4</td>
<td>2.72</td>
<td>7</td>
<td>8</td>
<td>34</td>
<td>180</td>
<td>Failed</td>
</tr>
<tr>
<td>5</td>
<td>4.08</td>
<td>6</td>
<td>9</td>
<td>64</td>
<td>223</td>
<td>Failed</td>
</tr>
<tr>
<td>6</td>
<td>16.88</td>
<td>3</td>
<td>14</td>
<td>80</td>
<td>200</td>
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<td>7</td>
<td>15.88</td>
<td>3</td>
<td>9</td>
<td>42</td>
<td>150</td>
<td>&quot;</td>
</tr>
<tr>
<td>8</td>
<td>21.4</td>
<td>3</td>
<td>12</td>
<td>40</td>
<td>212</td>
<td>Failed</td>
</tr>
<tr>
<td>9</td>
<td>21.4</td>
<td>3</td>
<td>10</td>
<td>55</td>
<td>380</td>
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<td>10</td>
<td>77.52</td>
<td>2</td>
<td>17</td>
<td>110</td>
<td>203</td>
<td>&quot;</td>
</tr>
</tbody>
</table>

*p, IAP. P0.1 and Pes are expressed in cmH2O.
*p, patients not extubated because of complications.

3 out of 5 patients with no IAH, and 1 out of 5 patients with IAH, failed the weaning and it was necessary to re-intubate them within 24 hours; 2 out of 5 patients with IAH succeeded the weaning.

Conclusions: In these series there is no correlation between IAP and P0.1 values. P0.1 < 4, f/Vt < 100 and PaO2/FiO2 > 200 were prognostic for successful weaning.

Reference:

A-605
CT scan assessment of malpositioned chest tube in intensive care patients

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Background and Goal of Study: Percutaneous chest tube placement for pleural effusion or pneumothorax is a frequent procedure in intensive care unit. Severe complications due to malpositioned chest tubes such as lung lacerations and fatal bronchopleural fistula have been reported [1]. However, the incidence of malpositioned chest tube in critically ill patients has never been prospectively studied. The aim of the study was to assess its incidence.

Materials and Methods: We underwent a one year prospective descriptive study in our surgical intensive care unit. During this period, all patients with a percutaneous chest tube were screened. Patients with such a tube in place in whom a thoracic computed tomographic scan (TCT) was acquired for clinical reasons (sepsis, acute respiratory distress syndrome, ineffective thoracic drainage, etc) were included for the analysis. Based on the TCT findings, chest tube position was classified as pleural, extrathoracic, infrasural or intraparenchymatous.

Results and Discussion: Among 122 chest tubes placed in 75 adult patients (age = 51 ± 19, SAPS II = 38 ± 16) during the study, 106 chest tubes in 63 patients (age = 49 ± 19, SAPS II = 39 ± 16) were visualized on TCT. The mean delay between tube placement and TCT was 3.5 ± 2.9 days (from 1 to 13 days). Chest tubes were placed for sterile pleural effusion (50%), and/or for pneumothorax (40%), and/or for hemothorax (20%), and/or for pleural empyema (2%). Thirty-two chest tubes (30%) were malpositioned: (extrathoracic tube = 0, infrasural tubes = 22, intraparenchymal tubes = 10).

Using clinical and standard chest X Ray, less than 1% malpositioned chest tube has been reported in large retrospective studies [2].

Conclusion(s): Chest tube malposition is an underestimated complication in critically ill patients. A reassessment of the indications as well as the technique for placement of this routinely used procedure is necessary to reduce its potentially deleterious side effects.

References:

A-606
Incidence of ventilator associated pneumonia (VAP) according to different enteral feeding techniques

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Background and Goals of Study: VAP is the most frequent nosocomial infection in intensive care units [1]. Colonization by gastropulmonary route plays a basic role in VAP pathogenesis [2]. Enteral feeding that is related to gastric contents alkalization, gastroesophageal reflux stimulation and colon- ization of upper respiratory tract increases the risk of VAP. The aim of the study was to assess the incidence of VAP according to use of intermittent (IEF) or continuous (CEF) enteral feeding techniques.

Materials and Methods: Prospective randomized study included 30 patients with an expected mechanical ventilation period of at least 6 days. They were divided into two groups: A (n = 15) fed by IEF technique, and B (n = 15) fed by CEF technique. The patients with history of alimentary tract disorders, gastropathy, and H2-receptor antagonists or proton pump inhibitors treatment were excluded from the study. pH of gastric contents taken by gastric tube was examined by CP-315 pH-meter. The changes of pH were evaluated by nonparametric Wilcoxon test. The diagnosis of VAP was based on clinical, radiological and bacteriological criteria (tracheobronchial aspirate and protected specimen brush). Significance of differences in VAP incidence was assessed by Fisher exact test.

Results and Discussion: The study included 30 patients – 7 females and 23 males aged 15–70 years. A statistically significant decrease of pH during night feeding break was stated in patients from group A (p < 0.01). This made a prevention of gastric colonization and VAP development in this
group and incidence of VAP was 20%. In group B the pH changes were not statistically significant and incidence of VAP was 33%. The difference between incidence of VAP in both groups was not statistically significant (p = 0.34).

Conclusion: IEF technique can be used to obtain a temporary increase of gastric contents acidity that inhibits gastric colonization, however, this does not cause a statistically significant decrease in incidence of VAP.

References:

A-607
Evaluation of perioperative and late complications after the percutaneous tracheostomy
Department of Anaesthesiology and Intensive Therapy, Medical University of Gdańsk, Gdańsk, Poland

Background and Goal of Study: In patients with long-lasting mechanical ventilation it is recommended to perform an early tracheostomy. In the last years the development of the percutaneous dilatational tracheostomy (PDT) technique is observed. Perioperative complications rate of the PDT is lower than the morbidity of the conventional open surgical tracheostomy (ST). Materials and Methods: In the previous two years in 111 patients treated in the Intensive Care Unit with mechanical ventilation longer than 8 days, who were older than 18 years, without observed anomalies in the neck and without diagnosed coagulopathy the elective PDT procedure was performed using the Griggs technique. In 111 patients perioperative morbidity was evaluated, that occurred in the first 24 hours after the procedure. Additionally in 50 patients who survived more than 6 months after the discharge from the ICU the late complication rate was evaluated.

Results: Rate and type of complications is presented in the table:

<table>
<thead>
<tr>
<th>Perioperative complications</th>
<th>Number</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bleeding</td>
<td>2</td>
<td>1.8</td>
</tr>
<tr>
<td>Pneumothorax</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>Subcutaneous emphysema</td>
<td>2</td>
<td>1.8</td>
</tr>
<tr>
<td>Infection</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>Revision of the fistula</td>
<td>1</td>
<td>0.9</td>
</tr>
</tbody>
</table>

Late complications: In one patient symptomatic tracheal stricture was observed, what gives 0.9% of performed procedures. Complications were observed in 8 patients (7.2% of the performed procedures).

Conclusion(s): 1. No life-threatening complications and no deaths were observed as the complication of the procedure. 2. The only observed late complication was symptomatic stricture, that required surgical treatment. 3. Proper selection of the patients and surgeon’s experience result in a complication rate after PDT that is not higher than after ST.

References:

A-608
Minimally invasive percutaneous dilatational tracheostomy: our experience
D.C. Ristani, A. David, R. Messina, A. Noto, M. Barone, A.U. Sinardi
Anestesia e Rianimazione, Emergenza Medico Chirurgiche Messina, Italy

Background and Goal: To present our experience with Percutaneous Dilatational Tracheostomy (PDT).

Material and Methods: We performed 97 consecutive PDT by Percutwist technique (Rush, Kernen, Germany). The indications for tracheostomy included prolonged mechanical ventilation and/or difficult weaning.

The procedure is performed, through a small incision of the skin, using a Seldinger technique for inserting the tracheal cannula, while the dilatation is obtained by the rotation of a twist. This technique allows the tracheal wall to hold open during the dilatation process by elevation of the anterior tracheal wall and avoid the damage to the posterior wall. Once the end of the thread twist can be seen endoscopically, the greatest degree of dilation and penetration has been achieved(1).

In our experience tracheostomy was defined “early” if performed within the 10th day of mechanical ventilation and “late” if performed thereafter.

Discussion and Results: 97 patients (M – 56; F – 41) were admitted in ICU for different diseases: patients with severe trauma; 23; COPD: 19; cerebrovascular diseases: 29; other causes: 26. Early tracheostomy was performed in 45 patients while 52 received late tracheostomy.

Completion of the procedure consumed 7–20 minutes (mean, 14 minutes). The procedure caused complications in only one patient: a subcutaneous bleeding few hours after the procedure in a patient who was already treated with low molecular weight heparin.

In our experience late complications did not arise. The follow up was performed using a simple questionnaire by phone on the third and on the sixth month.

Conclusion(s): In our experience, according to the international literature, the PDT seems to be the elective procedure for prolonged airway management in high-risk intensive care patients and for weaning from mechanical ventilation.

The procedure is safe, simple, fast, cost-effective, with low incidence of perioperative or postoperative complications, so we feel this technique as preferable for routine in ICU patients.

Reference:

A-609
Routine chest radiography following percutaneous dilatational tracheostomy
M. Hughes, E. Clark, G. Dampsey
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Background and Goal of Study: The role of routine chest radiography (CXR) following percutaneous dilatational tracheostomy (PDT) has recently been questioned.

Materials and Methods: We have performed a prospective observational study on 106 patients undergoing PDT under bronchoscopic guidance to assess the utility of routine postoperative chest radiography. Data was collected on all patients undergoing PDT from 1/1/03–1/12/04. Two post procedural CXRs were reviewed and compared with those taken prior to PDT. Significant findings were barotrauma (pneumothorax, pneumomediastinum) and consolidation not noted on the pre procedure film. Post procedural films reviewed were those taken immediately after PDT and, to exclude the possibility of overlooking evidence of minor barotrauma, one further film taken between 24–96 hours.

Results and Discussions: 106 patients underwent PDT. 80 (75%) were uncomplicated. Complications were recorded in 25 (25%), 91 (86%) patients had 2 post procedural CXRs reviewed and compared with those taken prior to PDT. Significant findings were barotrauma (pneumothorax, pneumomediastinum) and consolidation not noted on the pre procedure film. Post procedural films reviewed were those taken immediately after PDT and, to exclude the possibility of overlooking evidence of minor barotrauma, one further film taken between 24–96 hours.

Conclusion(s): Routine CXR following uncomplicated PDT is not warranted. The role of CXR following PDT appears to be restricted to those patients undergoing complicated procedures. This will lead to reductions in both medical costs2 and exposure of staff and patients to ionising radiation.

References:

A-610
Influence of perioperative fluid infusion on pulmonary complications after oesophagectomy
Department of Anaesthesiology and Intensive Care, University Hospital of Lille, Lille, France

Background and Goal of Study: Pulmonary complications (PC) are frequent after oesophagectomy reaching 20 to 40% of the operated patients.

In our experience tracheostomy was defined “early” if performed within the 10th day of mechanical ventilation and “late” if performed thereafter.

Discussion and Results: 97 patients (M – 56; F – 41) were admitted in ICU for different diseases: patients with severe trauma; 23; COPD: 19; cerebrovascular diseases: 29; other causes: 26. Early tracheostomy was performed in 45 patients while 52 received late tracheostomy.

Completion of the procedure consumed 7–20 minutes (mean, 14 minutes). The procedure caused complications in only one patient: a subcutaneous bleeding few hours after the procedure in a patient who was already treated with low molecular weight heparin.

In our experience late complications did not arise. The follow up was performed using a simple questionnaire by phone on the third and on the sixth month.

Conclusion(s): In our experience, according to the international literature, the PDT seems to be the elective procedure for prolonged airway management in high-risk intensive care patients and for weaning from mechanical ventilation.

The procedure is safe, simple, fast, cost-effective, with low incidence of perioperative or postoperative complications, so we feel this technique as preferable for routine in ICU patients.

Reference:
In case of thoracic surgery, intraoperative excessive fluid infusion has been identified as a risk factor for PC [1]. To our knowledge, no study has ever specifically studied the influence of perioperative fluid administration on the emergence of PC in patients operated for oesophagectomy.

**Materials and Methods:** We reviewed retrospectively 196 patients undergoing oesophagectomy with (n = 190) or without (n = 6) thoracotomy over a 5-year period (1999 to 2004). Patients were divided into 2 groups according to the presence or not of PC. PC was defined as presence of pneumonia with lung infiltrate and purulent sputum and/or acute lung injury (ALI) and/or acute respiratory distress syndrome (ARDS). Age, surgery time, intraoperative fluid infusion (IF), intraoperative amount of colloid and crystalloid, fluid infusion (FI) during the first 24 h, cumulated intra- and postoperative FI (CFI), intensive care unit (ICU) and hospital length of stay and 28-day mortality were registered.

**Results and Discussions:** Data are mean ± SD.

<table>
<thead>
<tr>
<th>PC (+)</th>
<th>PC (-)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(n = 135)</td>
<td>(n = 81)</td>
</tr>
<tr>
<td>Age (year)</td>
<td>59 ± 9</td>
</tr>
<tr>
<td>Surgery time (min)</td>
<td>370 ± 76</td>
</tr>
<tr>
<td>IF (ml - kg⁻¹ - h⁻¹)</td>
<td>11.4 ± 4.0</td>
</tr>
<tr>
<td>Colloids (L)</td>
<td>1.9 ± 0.6</td>
</tr>
<tr>
<td>Crystalloids (L)</td>
<td>2.9 ± 0.8</td>
</tr>
<tr>
<td>FI at 24h (L)</td>
<td>7.1 ± 1.2</td>
</tr>
<tr>
<td>CFI (ml - kg⁻¹)</td>
<td>102 ± 25</td>
</tr>
<tr>
<td>ICU stay (D)</td>
<td>3.2 ± 1.43</td>
</tr>
<tr>
<td>Hospital stay (D)</td>
<td>11.4 ± 1.8</td>
</tr>
<tr>
<td>Death (n%)</td>
<td>1.0 (7.6%)</td>
</tr>
</tbody>
</table>

PC (+) vs PC (-): Wilcoxon test or Fisher’s test, *p < 0.05.

**Conclusion:** Even if intraoperative fluid infusion was not different between the two groups, early postoperative fluid intake might influence pulmonary morbidity after oesophagectomy.

**References:**

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**A-612**

Development of a pig model of neurogenic pulmonary edema

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**Background and Goal of Study:** The inflammatory reaction following brain death (BD) in the heart-beating donor may rapidly result in neurogenic pulmonary edema (NPE) contributing to the critical organ shortage in lung transplantation. Further study of the pathophysiological changes in a large animal model may direct strategies to increase donor lung availability in humans. Currently, no large animal model of NPE following acute increase of intracranial pressure (ICP) exists.

**Materials and Methods:** Pigs were divided in two groups (n = 6/group). In group I [BRAIN DEATH – BD] brain death was induced by increasing ICP to 200 mmHg with an epidural balloon catheter. In group II [CONTROL – C] the balloon was not inflated. Functional parameters and catecholamine levels were measured during 1 hour. After explantation Wat-to-Dry weight ratio was calculated.

**Results and Discussion:** A clear cushing response was observed in BD. Adrenaline and Noradrenaline levels in BD peaked at 1 min and 5 min, respectively and were significantly (p < 0.05) higher compared to C (5.23 ± 1.50 µg/L and 4.11 ± 2.50 µg/L versus 0.20 ± 0.09 µg/L and 0.08 ± 0.02 µg/L, respectively). Functional parameters (mean ± SEM) are listed in Table:

<table>
<thead>
<tr>
<th>Time</th>
<th>30’</th>
<th>60’</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAP (mmHg)</td>
<td>BD</td>
<td>19.4 ± 4.0</td>
</tr>
<tr>
<td>C</td>
<td>19.2 ± 3.8</td>
<td>20.1 ± 3.9</td>
</tr>
<tr>
<td>COMPL (ml/cmH2O)</td>
<td>BD</td>
<td>30.8 ± 2.6</td>
</tr>
<tr>
<td>C</td>
<td>27.4 ± 1.9</td>
<td>42.3 ± 3.8</td>
</tr>
<tr>
<td>PO2/FIO2 (mmHg)</td>
<td>BD</td>
<td>549.6 ± 26.2</td>
</tr>
<tr>
<td>C</td>
<td>506.6 ± 5.0</td>
<td>561.2 ± 15.2</td>
</tr>
<tr>
<td>W/D</td>
<td>BD</td>
<td>4.99 ± 0.20</td>
</tr>
<tr>
<td>C</td>
<td>4.68 ± 0.32</td>
<td></td>
</tr>
</tbody>
</table>

* p < 0.05. No significant differences were observed in BD versus C and at 30’ versus 60’. (Mann-Whitney U test).

**Conclusions:** (1) Though not significant, lung function slightly deteriorated within the first hour in BD compared to C. (2) In contrast to other animal models, this is the first evidence that a longer evaluation after increased ICP is needed in pigs to develop NPE.

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**A-613**

Immunomonitoring in severe sepsis: which anti-inflammatory cytokines to measure?

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*Clinic of Anesthesiology and Intensive Therapy, Military Medical Academy, Belgrade, Serbia and Montenegro*

**Background and Goal of Study:** Severe sepsis is the major source of morbidity and mortality despite the rapid development of intensive therapy. Studies have indicated that there are marked alterations in immune response in patients with severe sepsis including altered pro- and anti-inflammatory mediator/cytokine release [1]. Aim of this study was to assess the prognostic value of anti-inflammatory cytokines: interleukin (IL)-1 receptor antagonist (IL-1ra), IL-4, IL-10 and transforming growth factor (TGF)-beta 1 regarding severity and outcome in patients with severe sepsis.

**Materials and Methods:** Thirty five patients with well-documented sepsis were enrolled in this study. Sepsis severity score (Elebute and Stoner, revised by Grundman, 1988) was from 3 do 36. Twenty eight patients developed MODS and 21 died. Blood was drawn on the first, third and fifth day of onset of sepsis. Concentrations of IL-1ra, IL-4, IL-10 and TGF-beta 1 were determined in plasma using ELISA assays.

**Results and Discussions:** When compared MODS group with group without MODS, we found statistically highly significant difference (p < 0.01) in IL-1ra and IL-10 concentrations; mean values of IL-1ra were 6-fold higher and IL-10 70-fold higher in patients with MODS; IL-4 and TGF-beta 1 were not statistically different (p > 0.05) between two groups. When compared non-survivors with survivors, we found statistically highly significant difference (p < 0.01) in IL-1ra and IL-10 concentrations; mean values of IL-1ra were 2.7-fold higher and IL-10 1.4-fold higher in non-survivors; IL-4 and TGF-beta 1 were not statistically different (p > 0.05) between two groups.
A-614

Correlation between pro-inflammatory response and severity and outcome of trauma
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Background and Goal of Study: The cytokine cascade activated in response to injury consists of a complex biochemical network with diverse effects on the injured host. Studies have indicated that there are significant alterations in pro-inflammatory response in patients exposed to major trauma or prolonged surgical procedures (1). Aim of this study was to assess pro-inflammatory response to trauma.

Materials and Methods: Twenty five patients with severe trauma who developed MODS and 10 patients with less severe trauma (without MODS) were enrolled in this study. In the trauma + MODS group 14 died. In trauma group 2 died. Blood was drawn on the first, third and fifth day of trauma. Concentrations of IL-8, IL-12, tumor necrosis factor (TNF)-alpha and interleukin-10 (IL-10) were determined in plasma using ELISA assay

Results and Discussions: When compared trauma + MODS group with trauma group we found that mean values of IL-8 were 230-fold higher (p < 0.05) and TNF-alpha 17-fold higher (p < 0.05) in patients with trauma + MODS; IL-12 was not statistically different (p > 0.05) between two groups. When compared non-survivors with survivors, we found that mean values of IL-8 were 2.3-fold higher in non-survivors (p < 0.01), mean values of TNF-alpha were 2.2-fold higher in non-survivors (p < 0.01), IL-12 was also higher in survivors (p < 0.05). IL-10 was also higher in survivors (p < 0.05). IFN-gamma was not statistically different (p > 0.05) between two groups.

Conclusion(s): There is augmented pro-inflammatory response after trauma. High concentrations of IL-8 and TNF-alpha indicated higher severity (MODS). But, fatal outcome was predicted with high concentrations of IL-8 only; survivors had higher concentrations of TNF-alpha and IL-12.

Reference:

A-616

What are the causes of increased procalcitonin values in brain-dead organ donors?
Department of Anaesthesia and Intensive Care, CHU de Nancy, Vandoeuvre-les-Nancy, France

Background and Goal of Study: Procalcitonin (PCT) is a polypeptide whose concentration is very low/undetectable in healthy patients. Its increase above 2 ng/ml is predictive of severe bacterial or fungal infections but non-infectious causes of increased PCT values have been reported. Several recent reports have documented an association between increased PCT values in brain-dead organ donors (BDOD) and altered graft function in the receiver but the causes of increased PCT values in BDOD are not known. The aim of this study was to investigate possible causes of increased PCT in BDOD.

Materials and Methods: We retrospectively analysed 100 consecutive BDOD and investigated the initial causes that lead to BD, several demographic and clinical parameters, results of bacterial cultures (blood, urine, tracheal suction samples), prescriptions of antibiotics and the plasma values of PCT measured before organ harvesting. We designated as infection either a positive bacterial culture and/or prescriptions of antibiotics.

Results and Discussions: The median values of PCT were of 1.5 (25–75 percentiles: 0.4–6.3) ng/ml. A value of PCT above 2 ng/ml was observed in 38 patients. The increase in PCT values was not associated with any of the definitions of infection. The only predictive factor of PCT increase was cerebral anoxia (e.g. strangulation, cardiac arrest) as the initiating event that lead to BD.

Conclusion: Our results confirm that PCT is increased in BDOD and bring suggestive evidence that this is not related to an infectious cause although diagnostic difficulties of infection should render the interpretation of these observations cautious. We suggest that brain anoxia could be one of the factors that explains increased PCT values in BDOD.

A-617

Role of 3-nitrotyrosine in Escherichia coli LPS-induce vascular hyporeactivity in rats
L. Jing, J. Li
Department of Anesthesiology, College of Medicine & Zhong-Da Hospital, Soo, Nanjing, China

Background and Goals: To observe the pathological role of 3-nitrotyrosine (3-NT) on Escherichia coli LPS-induced vascular hypovaccucity in rats and the therapeutic effect of antioxidants.

Material and Methods: Forty male SD rats with weight from 200 g to 250 g were randomly divided into four groups: the control group (n = 10); Escherichia coli LPS-induced septic shock group (n = 10); uric acid treated group (n = 10) melatonin treated group (n = 10). 6 h after LPS shock, apply phenylephrine (0.5–2.5 μg·kg⁻¹) intravenously to all groups and record the percentage increased in MAP, respectively. The concentration-response curve of aorta rings from all groups rats were obtained by cumulative addition of phenylephrine PE and calculated PE Emax, EC₅₀. The concentrations of plasma malondialdehyde (MDA), nitrate/nitrite and 3-NT were assayed in all groups after 6 h LPS shock.

Results: The MAP level induced by PE significantly decreased to 54.6% in LPS shock rats compared with the controls (P < 0.05). However, PE induced MAP level increased 37.7% and 43.05% in uric acid and melatonin treated rats respectively comparing with the LPS shock rats (P < 0.05). The maximum response and EC₅₀ to PE were significant reduced in LPS shock rats compared with control group (P < 0.05); but the reactivity of aorta to PE was improved obviously in uric acid and melatonin treated groups (P < 0.05).

The plasma concentration of MDA, nitrate/nitrite and 3-NT were much lower in uric acid and melatonin groups compared with the LPS shock group (P < 0.05).

Conclusions: 3-NT is an important pathological factor on vascular hyporeactivity in Escherichia coli LPS-induced septic shock. Antioxidants effectively improve α-adrenergic receptor mediated vascular reactivity in LPS shock rats partially by removing lipid peroxidative production, reducing nitric oxide and 3-NT biosynthesis.

A-618

Nitric oxide down-regulate alpha1-adrenergic receptors gene express in rat vascular smooth muscle cells
L. Jing, L.-J. Liao, J. Li
Department of Anaesthesiology, College of Medicine & Zhong-Da Hospital, Soo, Nanjing, China

Background and Goal of Study: The heightening of safety and efficiency of regional anaesthesia for the patients of elderly age is an actual problem. We study efficiency and safety of an epidural anaesthesia in a combination with Dizepamum for patients in elderly age.

Materials and Methods: The study was prospective. 44 patients who have transferred traumatological operations were inspected out. All patients separated into 2 groups. In I group (n = 21) was performed epidural analgesia/anaesthesia by Lidocainum in a combination with Dizepamum (0–10 mg). In II group (n = 23) to local anesthetic added morphine (3–5 mg). The chosen groups had no essential differences on age. Learning of intraoperation anaesthesia efficiency and rating of postoperative pain intensity were carried out by the different experts. The patients previously gave the written approval to carrying out of an anaesthesia and operation.

Results and Discussions: In 16–20 minutes after epidural introduction of Dizepamum the patients covered; the level of sedation was 4.3 ± 0.2 numbers (M.A. Ramsay et al., 1974). The level of sensor block reached Th₅₋₆, the pain sensitivity disappeared in 14–18 min. The duration of operation was 105.7 ± 15.6 min, to the end of the operation the patients have woken up. Complications, bound with carrying out epidural analgesia/anaesthesia, in I group was not observed. In II group patients were in a status of surface dream, thus in PCT level made 1.4 ± 0.1 numbers (p < 0.05). The duration of operations was 128.0 ± 25.8 min. At the same time, for a part of the patients of II group after the operation the following complications – depression of breath for 1 patient, expressed dermal itch for 4 patients were observed.

Conclusion: Our results confirm that PCT is increased in BDOD and bring suggestive evidence that this is not related to an infectious cause although diagnostic difficulties of infection should render the interpretation of these observations cautious. We suggest that brain anoxia could be one of the factors that explains increased PCT values in BDOD.
observed. The matching of postoperative pain intensity in the chosen groups has not detected an essential variance. The multiplicity of NSAID deriving nor differed. Therefore, efficiency of an epidural ataralgia/ anaesthesia by way of preventive measures of postoperative pain not differ from an epidural analgesia by morphine.

Conclusion(s): The absence of depressive influence on respiratory center at epidural introduction of ataractics alongside with effective preventive measures of postoperative pain makes to perspective usage of epidural ataralgia/anaesthesia in a gerontological anesthesiology.

A-619

Neostigmine does not attenuate organ injury in murine endotoxaemia: there are still missing points about the cholinergic anti-inflammatory pathway

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Background and Goal of Study: Stimulation of the efferent cholinergic antiinflammatory pathway suppress the systemic inflammatory response and can prevent endotoxaemia. Our aim was to investigate the effects of neostigmine- a cholinergic agent that has not been tested for this purpose- on histopathological organ injury in endotoxaemia.

Materials and Methods: 54 male albino mice (20–40 g) were included in a double-blind placebo controlled study. Group I (n = 12): Control group, Group II (n = 10): Endotoxin (Etx), Group III (n = 12): Neostigmine (Neo) 0.1 mg/kg, Group IV (n = 12): Etx + Neo 0.1 mg/kg, Group V (n = 4): Neo 0.3 mg/kg, Group VI (n = 4): Etx + Neo 0.3 mg/kg. Endotoxin was derived from Escherichia coli (O55:B5). All drugs were injected ipaperitoneally at equal volumes and repeated every 6 hours for 3 days. On the 3rd day, all mice were killed by cervical dislocation and organs were dissected for histopathological examination by a pathologist who was blinded to the group assignment. The tissue injuries were graded on a four point scale (0–3). Kruskal Wallis, Mann-Whitney U tests were used for statistical analysis. P < 0.05 considered as significant.

Results and Discussions: 1 mouse in group I, 2 mice in group II, 3 mice in group IV, 2 mice in group V, all mice (4) in group VI died before 3 days. In Neo 0.1 group, perivascular inflammation in the lung (median [95% CI] score: 0[0–1]) was lower than Etx (1[0–2]) and control groups (1[0–2]). The interstitial inflammation in lung was more prominent in the Etx group (2[1–3]) compared to the control (1[1–3]) and the Etx + Neo 0.3 group (1[1–1]). Vascular degeneration in liver was lower in Etx + Neo 0.3 group (0[0–0]) compared to etx group (1[0–2]). The liver injury score was highest in etx group (3[2–5]) and was lower in Neo 0.3 group (0[0–3]) than the control group (1.5[1–3]) There were no differences between Etx and Etx + Neo 0.1 groups regarding organ injury.

Conclusions: Neostigmine at a dose of 0.1 mg/kg was not protective against histopathological organ injury in endotoxaemia and 0.3 mg/kg was not tolerated probably due to non-specific parasympathetic action including cardiovascular effects.


A-620

Effects of propofol vs. methohexital on neutrophil function and immune status in critically ill patients

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Introduction: Sedatives, i.e. propofol and methohexital, have a variety of negative side effects on neutrophil leukocytes, lymphocytes and monocytes which all play a vital role in the defense against invading micro-organisms [1]. In this study, we investigated these effects in critically ill patients with long-term sedation.

Patients and Methods: In this observational clinical study, we analyzed 21 critically ill patients with long-term sedation who either received propofol (n = 12, APCACHE II 26 ± 4) or methohexital (n = 9, APCACHE II 28 ± 6) after ICU admission. Patients in the propofol group (P) (9 male, 3 female) had a mean age of 55 ± 15 years. In the methohexital group (M) (8 male, 1 female) mean age was 48 ± 18 years. Both sedatives were administered according to clinical requirements. Neutrophil leukocyte function was assessed as phagocytosis and respiratory oxidative burst activity. Furthermore, cellular markers of monocytes and lymphocytes (CD3, CD4, CD8, CD19, CD57, CD122) were assessed. Measurements were made on ICU admission, day 3, day 7 and day 14 of drug administration. Patients’ demographics and results were compared by Mann-Whitney U test and one-way repeated measurements ANOVA with an all-pair-wise multiple comparison procedure.

Results: Both groups were well matched in terms of age, height and body weight. ICU length of stay was comparable (22 ± 7 vs. 20 ± 9 days). Mortality was 0/12 and 2/9, respectively. Absolute numbers of leukocytes and sub-populations were comparable between both groups at each time point. We found no difference in neutrophil oxidative burst and phagocytosis within and between both groups at the different time points. With respect to lymphocyte and monocyte CD marker expression, no differences within each group and between the time points were found.

Conclusion: Effects of methohexital and propofol on neutrophil leukocyte function, expression of lymphocyte and monocyte markers were not different in critically ill patients with long-term sedation.


A-621

Edaravone attenuated LPS-induced cytokines production in human whole blood


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Background and Goal of Study: Edaravone (3-methyl-1-phenyl-2-pyrazolin-5-one), a brand-new drug for cerebral infarction, has been considered to have a therapeutic effect on endotxin shock due to its scavenging action on a hydroxyl radical, which is an important factor in critically septic patients. The results of previous experimental studies have suggested an inhibitory action of edaravone on cytokines production (1,2). However, whether or not edaravone attenuates cytokines production in human whole blood is still unproven. Therefore, we investigated the effect of edaravone on tumor necrosis factor-alpha (TNF-α) and interleukin-10 (IL-10) production induced by LPS in human whole blood.

Materials and Methods: After human investigations committee approval, informed consent was obtained from 6 healthy volunteers. Blood samples were obtained in tumor necrosis factor-alpha (TNF-α) and interleukin-10 (IL-10) production. After various doses (0–300 µg/ml) of edaravone were added, whole blood was stimulated with LPS (10 ng/ml). Then the blood was incubated for 24 hours at 37°C in a carbon dioxide incubator and centrifuged to remove blood cells. Supernatant samples were collected and stored at -80°C until assay. Plasma TNF-α and IL-10 concentrations were quantified with enzyme-linked immunosorbent assay. Statistical analysis was performed with a non-parametric test. P < 0.05 was considered to be significant.

Results and Discussions: Edaravone attenuated significantly LPS-induced TNF-α production dose-dependently. Edaravone suppressed significantly LPS-induced IL-10 production at a concentration more than 30 µg/ml. Conclusions: The results of the present study show that edaravone inhibited not only TNF-α but also IL-10 production in human whole blood. These results suggest a possible therapeutic effect of edaravone on sepsis in humans.


A-622

Duodenotomy does not influence proximal duodenal motility

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Background and Aim of Study: The effects of surgical procedures on intestinal motility are still under debate [1]. In order to quantify the effects of duodenotomy on duodenal motility activity the present study used the electric impedance technique (IMP).

Materials and Methods: Ten pigs (32–40 kg) were instrumented under general anaesthesia with a central venous catheter (CVC) and a percutaneous enterogastrostomy (PEG) [2]. Duodenal phases I–II and the duration of the migrating motor complex (MMC) were measured by an IMP catheter, which was introduced into the proximal duodenum either via the PEG by endoscopy (group A), or through surgical placement via duodenotomy (group B). According to manometric criteria, the duodenal motor patterns
A-624
Use of Proton Pump Inhibitors (PPI) for prevention of gastrointestinal bleeding in ICU patients
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Background: Stress-related mucosal disease (SRMD) develops in patients in the ICU and can result in clinically important bleeding. The most common used medication for prevention are histamin-2-receptor antagonists and sucralfate [1]. However a study shown no effect of such a prevention on the frequency of significant gastrointestinal bleeding (2). Little is known about the effect of PPI on SRMD in the ICU setting.

Methods: Between 01/2001 and 12/2003 all patients with an ICU stay >24 h were entered into the study retro-spectively. All patients received 40 mg Pantoprazol (Altana Pharma Germany) daily. With the ICD 10 codes all patients with acute gastrointestinal bleeding were identified. Thereafter the patients charts were reviewed. Exclusion criteria were: known peptic ulcer, admission due to symptoms of acute gastrointestinal bleeding (AGB), no endoscopic verification, recently done gastric operation.

Results: 4406 patients were treated on the ICU. The ICD codes filtered 87 patients with AGB. Exclusion were: 58 patients with symptoms of AGB on admission, 9 patients with known peptic ulcer, 11 patients without endoscopic verification, 3 patients with a stay < 24 h.

The remaining 6 patients (0.14%) shown all the known risk factors (mechanical ventilation, coagulopathy) for AGB (3).

Conclusion: Stress-ulcer prophylaxis with PPI seems to be effective in the prevention of AGB in the ICU setting. In comparison with prophylaxis with histamin-2-receptor antagonists (2) the treatment with PPI appears more effective. All patients shown the known risk factors.

References:

A-625
Effect of the opioid antagonist MNTX on intestinal motility in vitro
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Background and Goal of Study: Apart from the desired analgetic effect, opioids have a pronounced inhibitory effect on intestinal peristalsis and result in a marked prolongation of gastrointestinal transit time (1). The aim of the study was to evaluate if the opioid antagonists naloxone and MNTX were able to restore peristalsis after induction of a complete block of peristalsis.

Materials and Methods: Guinea-pig small bowel segments were excised and mounted in a tissue bath. Luminal perfusion of the segments with Tyrode’s solution resulted in an increase of the intraluminal pressure until the pressure threshold (PT) was reached. A drug-induced increase of the PT is defined as inhibition of peristalsis, while a decrease of the PT is interpreted as a stimulation of peristalsis (2). Primarily a complete block of peristalsis was induced, adding sufentanil 3 nM to the tissue bath, before increasing concentrations of naloxone or MNTX were added.

Results and Discussions: Naloxone as well as MNTX restored peristalsis at least to baseline values in all tested concentrations.

References:
A-628
Remifentanil versus fentanyl for postoperative analgesia in critical ill adults
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Background and Goal of Study: Analgesia based sedation techniques are becoming more established in the ICU setting (1). The purpose of this study was to compare remifentanil and fentanyl infusions for analgesia in postoperative patients requiring mechanical ventilation.

Materials and Methods: After receiving ethical committee approval, a prospective randomized, double-blind study was performed. 44 adult ICU patients received infusion of either remifentanil 0.1 μg/kg/min or fentanyl 0.025 μg/kg/min diluted to the same volume. Analgesic infusion was titrated to Behavioral pain scale (BPS) score of 3. Propofol was added if sedation was unsatisfactory after BPS score 3 had been achieved. Chi-square, Mann-Whitney U tests were used for statistical analysis.

Results and Discussion: Data is given as number of patients (n) or median (95% CI) in the table below.

<table>
<thead>
<tr>
<th></th>
<th>Remifentanil</th>
<th>Fentanyl</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (yrs)</td>
<td>44 (16-80)</td>
<td>32 (16-76)</td>
</tr>
<tr>
<td>Female/Male (n)</td>
<td>13/12</td>
<td>15/16</td>
</tr>
<tr>
<td>Weight (kg)</td>
<td>70 (30-90)</td>
<td>50 (20-89)</td>
</tr>
<tr>
<td>Duration of operation (min)</td>
<td>240(120-660)</td>
<td>240(64-657)</td>
</tr>
<tr>
<td>ICU stay (days)</td>
<td>3(2-32)</td>
<td>22(13-32)</td>
</tr>
<tr>
<td>Mechanical ventilation (min)</td>
<td>114(685-1542)</td>
<td>1110(795-2670)</td>
</tr>
<tr>
<td>Propofol needed for sedation (n)</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Number of titrations</td>
<td>5(0-10)</td>
<td>40-9</td>
</tr>
<tr>
<td>Time to BPS score 3 (min)</td>
<td>12.50(480)</td>
<td>7.5(240)</td>
</tr>
<tr>
<td>Time to extubation (min)</td>
<td>105(580)</td>
<td>102(174)</td>
</tr>
<tr>
<td>Nurses’ assessment of analgesia</td>
<td>4(5)</td>
<td>6(5)</td>
</tr>
<tr>
<td>Nurses’ assessment of sedation</td>
<td>4(5)</td>
<td>5(5)</td>
</tr>
<tr>
<td>Physician’s assessment of analgesia</td>
<td>4(5)</td>
<td>5(5)</td>
</tr>
</tbody>
</table>

Remifentanil provided better analgesia at the start of the infusion; fentanyl provided better analgesia after cessation of the infusion. The incidences of complications were also similar between the two groups.

Conclusion: We conclude that remifentanil infusion provides clinically similar analgesia to fentanyl infusion in adult postoperative ICU patients.


A-627
Procalcitonin as an early prognostic marker of adverse outcome in patients with acute heart failure after complicated cardiac surgery
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Background and Goal of Study: Increased Procalcitonin (PCT) levels early after cardiopulmonary bypass (CPB) were correlated with higher risk of various events after heart surgery (1). The aim of our study was to determine whether PCT 10 ng/ml on day 1 after coronary artery bypass grafting (CABG) surgery predicts poor outcome in patient (pts) with acute heart failure.

Materials and Methods: 24 prospectively studied pts. after elective CABG surgery requiring CPB. Inclusion criteria: the need of epinephrine >0.1 μg/kg/min and intra-aortic balloon pump >16 hours after surgery; exclusion:pts. with chronic diseases, reoperation, urgent operation, preoperative LV ejection fraction (LVEF) 35%, mitral regurgitation > I degree and survival 48 hours after surgery. Plasma PCT, C reactive protein (CRP), cardiac output (CO) and LVEF were measured within 24 hours after surgery. Perioperative data expressed as Mean ± SD and compared using paired t-test. P < 0.05 was significant.

Results and Discussion: Two groups of pts: with PCT < 10 ng/ml (n = 12) and PCT > 10 ng/ml (n = 12). There were no significant differences in age, preop. LVEF, EuroSCORE. Longer CPB and cross-clamp were in PCT < 10 ng/ml group. Postop. data are shown in tables.

Table 1.

<table>
<thead>
<tr>
<th></th>
<th>PCT &lt; 10</th>
<th>PCT &gt; 10</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAPS-II</td>
<td>41.2 ± 4.3</td>
<td>61.5 ± 10.3</td>
<td>0.01</td>
</tr>
<tr>
<td>CRP mg/L</td>
<td>84.25 ± 35.5</td>
<td>64.7 ± 34.5</td>
<td>0.46</td>
</tr>
<tr>
<td>CO, L/min</td>
<td>5.3 ± 1.9</td>
<td>5.45 ± 2</td>
<td>0.9</td>
</tr>
<tr>
<td>LVEF, %</td>
<td>35.2 ± 11.3</td>
<td>35 ± 18</td>
<td>0.9</td>
</tr>
<tr>
<td>Ventilation, hour</td>
<td>7.47 ± 50.8</td>
<td>260 ± 185.8</td>
<td>0.089</td>
</tr>
<tr>
<td>ICU stay, day</td>
<td>8.7 ± 3</td>
<td>22 ± 17</td>
<td>0.175</td>
</tr>
</tbody>
</table>

Table 2.

<table>
<thead>
<tr>
<th></th>
<th>PCT &lt; 10</th>
<th>PCT &gt; 10</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurological</td>
<td>3/12 (25%)</td>
<td>6/12 (50%)</td>
<td></td>
</tr>
<tr>
<td>Renal</td>
<td>0/12 (0%)</td>
<td>9/12 (75%)</td>
<td></td>
</tr>
<tr>
<td>Sepsis</td>
<td>0/12 (0%)</td>
<td>9/12 (75%)</td>
<td></td>
</tr>
<tr>
<td>Death</td>
<td>0/12 (0%)</td>
<td>6/12 (50%)</td>
<td></td>
</tr>
</tbody>
</table>

Conclusion(s): PCT level 10 correlated with longer CPB, cross-clamp, higher SAPS II score, higher complications and mortality rate.


A-628
Differential effects of nitric oxide synthases on heme oxygenase-1 in the normal and stress exposed liver
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Background and Goal of Study: The heme oxygenase (HO) and the nitric oxide synthase (NOS) pathway, both, protect the liver from dysfunction under pathological conditions, such as inflammation or ischemia/reperfusion (1,2). Here, we studied the function of NOS and the effect of endogenously generated nitric oxide (NO) on HO-1 regulation in the normal and stress exposed liver.

Materials and Methods: Anesthetized male Sprague-Dawley rats (n = 5–7) received vehicle, N₆-nitro-L-arginine-methylster (L-NNAME), S-methylisothiourea (SMT), or Lipopolysaccharide (LPS). After 6h liver tissue was analysed for HO-1 and iNOS, by Northern, Western blotting, and necrosis by H&E staining. Data are presented as mean ± (SEM), and differences were determined by ANOVA.

Results and Discussion: Blockade of the constitutive isoform of the NOS (cNOS) by L-NNAME induced HO-1 mRNA in the normal liver (Table 1). This effect was associated with elevated AST and LDH activity (p < 0.05), and liver necrosis. The inducible NOS (iNOS) was not detectable in the normal liver. Moreover, inhibition of iNOS by SMT did not result in HO-1 induction, indicating that cNOS is primarily responsible for the suppressing action on HO-1 in the normal liver. In sharp contrast, following LPS challenge, blockade of iNOS led to an upregulation of HO-1 above LPS and control levels (Table 1).

Conclusion(s): Blockade of NO-synthesis upregulates HO-1 in the rat liver: The suppression of HO-1 by NO is based on the intact function of cNOS in the normal, and on iNOS in the stress exposed liver.

Table 1. Hepatic HO-1 mRNA, relative densitometric units.

<table>
<thead>
<tr>
<th></th>
<th>Control</th>
<th>L-NNAME</th>
<th>SMT</th>
<th>LPS</th>
<th>LPS + SMT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0 (±0.2)</td>
<td>8.9 (±2.2)</td>
<td>2.5 (±0.6)</td>
<td>3.6 (±0.4)</td>
<td>6.9 (±0.7)</td>
<td></td>
</tr>
<tr>
<td>1.4 (±0.3)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

p < 0.05 *vs control, #vs L-NNAME, †vs LPS.


Acknowledgements: This work was supported by the Deutsche Forschungsgemeinschaft (DFG, PA 533/4-1 to B.H.J. Pannen and A. Hoetzelt).

A-629
Mannitol and the prevention of lipid peroxidation during liver resection surgery
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Background and Goal of Study: We examined the efficacy of mannitol in the prevention of lipid peroxidation during major liver resections performed under hepatic inflow occlusion.

Materials and Methods: Thirty patients, ASA II–III were included in this prospective randomised study. All patients received combined general and
epidural anaesthesia. They were randomly allocated to either receive mannitol
20% 1.5 ml·kg⁻¹ (group M) or normal saline 1.5 ml·kg⁻¹ (group S) intra-
venously, before the performance of hepatic vascular occlusion. Venous blood malondialdehyde concentration (MDA), as an index of lipid peroxidation,
was measured spectrophotometrically at selected timepoints.

Results and Discussions: Patients in both groups presented with raised,
compared to baseline, MDA values (p < 0.05) for the period starting before
the release of vascular occlusion until six days postoperatively. In patients
receiving mannitol lower MDA values were observed (p < 0.05) compared
to group S at the end of operation.

Conclusion: Mannitol might have a free radical scavenging activity for a
short period after its administration to patients undergoing liver resection
surgery with inflow vascular occlusion, but it does not seem to produce a
sustained antioxidant effect after the end of operation. Furthermore, we
could not confirm a positive impact on the postoperative clinical course of
patients receiving mannitol.

Reference:
1 Seitzer N, Rudiger H, Graf R, Clavien P. Protective strategies against ischemic injury

A-630
Effects of PEEP on liver function and splanchnic microcirculation
A. Holland, O. Thuemer, C. Schelenz, S.G. Sakka
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Schiller-University, Jena, Germany

Introduction: The effects of positive end-expiratory pressure (PEEP) on
liver function and blood flow in experimental and clinical studies revealed
non-uniform results. In this clinical study, we investigated the effects of
PEEP on liver function (indocyanine green plasma disappearance rate, ICG-
PDR) and splanchnic microcirculation as estimated by regional PCO2
(PaCO2) using gastric tonometry.

Methods: With approval by our local ethics committee and written consent,
we studied 14 patients after elective coronary bypass surgery using extra-
corporal circulation (13 male, one female; age 48–74, mean 63 ± 7 years).
All patients underwent extended hemodynamic monitoring by a pulmonary-
artery catheter for clinical indication. ICG-PDR and gastric mucosal PaCO2
were assessed on ICU admission (PEEP 5 mbar), two hours after increasing
PEEP to 10 mbar and again after two hours at PEEP 5 mbar. In addition, car-
diac index (CI), central venous pressure (CVP) and left atrial pressure (LAP)
were measured. All patients were on pressure-controlled ventilation and
inotropic support was adapted to maintain PaO2 constant. Vasoactive drugs, blood pressure, minute volume and sedation were kept constant.

Results: CI significantly increased during the study. However, there was a
trend for ICG-PDR to change between the different time points (p = 0.05).
However, the difference between regional and arterial PCO2 (PaCO2-gap)
significantly increased following PEEP5 (1) and remained higher at PEEP5 (2)
than at PEEP5 (1).

A-631
Procalcitonin (PCT) versus markers of infection and their
impact on antibiotic prescribing in the ITU
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United Kingdom

Background and Goal: The markers traditionally used for diagnosing sep-
sis (pyrexia, tachycardia, tachypnoea, leucocytosis, raised C-reactive pro-
tein (CRP) are all non-specific markers of inflammation and are not sensitive
or specific for sepsis. Procalcitonin (PCT) can be used for the differential
diagnosis of bacterial infections, systemic inflammation and viral infection1.

We studied the relationship between PCT and markers of inflammation and
looked at the influence of PCT on decision-making in antibiotic prescription.

Materials and Methods: Retrospective and prospective study on an
adult intensive care unit. PCT tests were done after liaising with a consult-
ant microbiologist. Brahms® PCT-Q semi-quantitative immunochromato-
graphic tests were used with the ranges <0.5 ng·ml⁻¹, 0.5–2.0 ng·ml⁻¹,
2.0–10.0 ng·ml⁻¹ and >10 ng·ml⁻¹. Data on demographics, diagnosis, admis-
sion APACHE II scores, vital signs, inflammatory markers, microbiology cul-
tures and antibiotic prescription were recorded. For each PCT measurement
it was determined whether there had been a change of treatment within the
24 hours following it, and, in conjunction with a consultant in ICU and micro-
biology, whether the PCT level had been useful in the decision.

Results and Discussions: 101 PCTs with corresponding inflammatory
markers were measured in 30 patients (ApACHE 21 (mean), age: 53 ± (mean)).
Correlation (R²) between PCT and inflammatory markers was 0.005 for tem-
perature, 0.009 for WCC and neutrophils and 0.134 for CRP. On 59 (58%) occasions at least 2 of the SIRS criteria were present at the time PCT levels
were taken, 28 (28%) antibiotic decisions were found to be strongly influ-
enced by PCT levels.

Conclusions: “Usual” inflammatory markers correlate poorly with PCT.
PCT measurements enabled us to monitor success of antibiotic use and
gave us confidence to withhold and stop antibiotics although at times the
inflammatory parameters suggested otherwise. More rational use of antibi-
otics will have economical implications, which outweighs the costs of PCT
assays.


A-632
Characteristics of the long-stay (over twenty-eight days)
intensive care patient: an analysis of five years experience
B.O. Brien, H. Suhr, W. Butt, C.D. Scheinkestel
Department of Anaesthesia and ICU, AMNCH, Dublin, Ireland

Background and Goal of Study: Hypothermia may be therapeutic in stroke
victims; however, hypothermia provokes vigorous shivering. Doxapram
markedly reduces the shivering threshold (triggering core temperature) in
rabbits2 and has been shown to reduce postanesthetic shivering.2 However,
the effects of doxapram on thermoregulatory responses have not been
quantified. We thus determined the effect of doxapram on the major auto-
nomeric thermoregulatory responses in humans.

Materials and Methods: Nine healthy volunteers (5 men and 4 women, 18–40 yr) were studied on 2 days: Control (no drug) and Doxapram (target
plasma 4 µml, a fairly high dose). Core warming was started 15 min after
doxapram or saline administration when plasma concentrations were
near steady state. Each day, skin and core temperatures were increased to
provocate sweating and subsequently reduced to elicit peripheral vasoconstric-
tion and shivering. We arithmetically compensated for changes in skin temperature to
determine the sweating, vasoconstriction, and shivering thresholds. Sedation
was evaluated using Observer’s Assessment Sedation/Alertness scale. Paired
1 tests were used to identify differences between the days. Data presented
as means ± SDs; P < 0.05 was statistically significant.

Results and Discussions: Potential confounding factors were similar on both
study days. The sweating threshold was not affected by doxapram (Control:
37.5 ± 0.4°C, Doxapram: 37.3 ± 0.4°C, P = 0.29). However, doxapram
tended to reduce the vasoconstriction threshold (36.8 ± 0.7 vs. 36.4 ± 0.5°C;
P = 0.11) and significantly reduced the shivering threshold from 36.2 ± 0.5
°C to 35.7 ± 0.7°C (P = 0.012). Neither sedation nor symptoms of panic were
observed on either study day.

Conclusion(s): The observed reduction in the shivering threshold explains the
drug’s efficacy for treatment of postoperative shivering; however, a
reduction of only 0.5°C is unlikely to markedly facilitate induction of thera-
petic hypothermia as a sole agent.


A-633
The outcome of long-stay (over twenty-eight days) intensive
care patients: a follow-up study
B.O. Brien, H. Suhr, C.D. Scheinkestel, W. Butt
Department of Anaesthesia and Intensive Care, AMNCH, Dublin, Ireland

Background and Goal of Study: The outcome of patients spending one to
two weeks in intensive care has been studied [1,2] and appears to justify
such admissions [2]. The outcome of longer-stay patients is less clear however.

Materials and Methods: We identified a cohort of 68 patients who had spent 28 days or longer in our unit, having been admitted between July 2000 and July 2002. We recorded their Glasgow Outcome Score, by chart review or telephone, in the third quarter of 2003.

Results and Discussions: One was untraceable. Thirty-three were dead, including fourteen who died during their intensive care stay. Of the thirty-four survivors seventeen were living normal active lives, fifteen were disabled but independent, while only two were dependent on daily support. None were left vegetative.

Conclusion(s): In summary, one to three years after discharge, about half (49%) of the group had died, while a quarter lived normal active lives. While the remaining seventeen (23%) described some disability, only two patients needed daily support.

References:

A-634
Long-stay intensive care patients requiring readmission: incidence, admission characteristics and hospital outcome
B.O. Brien, H. Suh, C.D. Scheinkestel, W. Butt
Department of Anaesthesia and Intensive Care, AMNCH, Dublin, Ireland

Results and Discussions: Of 125 patients discharged from ICU after 28 or more days, 23 (18.4%) required readmission. This group included two patients readmitted twice and one readmitted four times (in total, 28 readmissions). Their average APACHE 2 score on readmission and survival to hospital discharge.

Conclusion(s): Long-stay ICU patients required readmission. Of this subgroup, 40% of 23 died during their stay in hospital, or immediately on discharge, while 60% (14 of 23) went home. Return to ICU after a long stay is rare, and clearly indicative of severe illness; however in this series most (60%) of these patients survived to discharge.

A-635
A comparison of mortality prediction systems in patients with diffuse bacterial peritonitis
D. Borisov, M. Kirov, D. Uvarov, E. Nedashkovsky
Department of Anesthesiology and Intensive Care, Northern State Medical University, Arkhangelsk, Russia

Conclusion(s): 15.6% of long-stay ICU patients required readmission. Of this subgroup, 40% of 23 died during their stay in hospital, or immediately on discharge, while 60% (14 of 23) went home. Return to ICU after a long stay is rare, and clearly indicative of severe illness; however in this series most (60%) of these patients survived to discharge.

A-636
Incidence and mortality related to ventilator-associated pneumonia
A. Hoxha, M. Demneri, K. Pilkia, O. Gjini, N. Filipi, M. Saraçi
Department of Anesthesiology and Intensive Care, University Hospital Center “Mother Theresa”, Tirana, Albania

Methods and Materials: The study was conducted in the Neurosurgery ICU of UHC of Tirana. During a 2-years period (2000–2003), all patients admitted to the ICU who had received mechanical ventilation were potentially eligible for the study. The study population consisted of 186 patients who for at least 48 hours at any point during their ICU stay. They were patients after intracranial operations (136 patients) and those with cranial and spinal trauma (52 patients). The diagnosis of VAP was defined as the occurrence of a new and persistent radiographic infiltrate not otherwise explained, appearing on chest radiograph along with 2 of the following: body temperature 38.3°C, leukocytosis (>10,000 WBC/ml; purulent tracheal aspirate (1)), p < 0.05 is considered as statistically significant.

Results: Over the period of the study, from the188 patients who received mechanical ventilation 72 patients (38.29%) developed VAP (55 traumatized and 17 post-operate). The onset of VAP was most likely to occur during the first 2 weeks of mechanical ventilation (46 or 63.9%). The duration of mechanical ventilation was longer among patients who suffered VAP compared with the patients who did not develop VAP (17.5 ± 6.7 days versus 9.0 ± 6.3 days, p < 0.01). In this study the mortality attributed to VAP was 26% (19 patients). Mortality was greater in the traumatized patients (15 patients or 78.95%).

Conclusion: Our study showed that VAP is one of the commonest pathology in the ICU patients treated with mechanical ventilation. VAP prolongs significantly the duration of mechanical ventilation and increase the mortality rate among intensive care units patients.

Reference:
the neurosurgical medical team. We evaluated these findings against the criteria for ICU admission of the American College of Critical Care Medicine (1).

Results and Discussions: Patients requiring ICU admission in need of extensive intensive treatment (priority 1 – emergency cases) and patients requiring intensive neuromonitoring with possible intervention (priority 2 – monitoring cases) comprised 77% and 23% respectively. Criteria for ICU admission decision (in order of significance) were: prognosis of underlying and acute disease, characteristics of tumor location, type of neurosurgical operation, age, number of available beds and legal liability. Non medical criteria did not influence decision. Preoperative neurological APACHE III score on ICU admission was 1.5 ± 0.45 and 18.20 ± 1.40 respectively and total APACHE III score was 17.83 ± 3.19 and 33.65 ± 2.37 in priority 1 and 2 patients respectively. Postoperative neurological APACHE III score on ICU admission was 4.16 ± 1.16 and 20.25 ± 1.62 respectively and total APACHE III score was 38.18 ± 4.16 and 51.40 ± 2.86 in priority 1 and 2 patients respectively.

Conclusion(s): The APACHE III and postoperative neurological sub score were good predictors of outcome in priority 2 but not priority 1 patients (p < 0.00062). The criteria for ICU admission complied fairly well with the American College of Critical Care Medicine guidelines.

Reference:

Acknowledgement: The University of Athens Neurosurgical Clinic of Evangelismos Medical Hospital.

A-638
Predictive value of unmeasured ion component of base excess in septic patients with the high risk of death
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Background and Goal of Study: The effect of Stewart's independent variables: strong ion difference and total weak acid concentration, allows the assessment of an unmeasured ion component (UIC) of the base excess (BE). The UIC and the standard BE < -5 mEq/l were associated with the increased risk of death (1,2). We decided to compare the standard BE and the effects of Na–Cl difference, albumin and UIC, in patients with severe sepsis (SAPS II > 40), who survived or died.

Materials and Methods: The following variables were based on data collected during the first day of admission and were determined (mEq/l) according to simplified Fenci-Stewart method (2): (a) standard BE – from arterial blood gas analysis; (b) Na–Cl effect = [Na+] – [Cl–] × 38; (c) Alb effect = 25 × [(Alb – 42) / (albumin (g/l)); and (d) UIC = standard BE – Na–Cl effect – Alb effect.

Results and Discussions: Among 25 studied patients, 13 survived and 12 died. There were no significant differences in demographic data. The standard BE and UIC were significantly lower, and UIC < -8 mEq/l was observed more often in critically ill septic patients, who died than those who survived, but the Na–Cl and Alb effects on BE were not different between both groups.

Survived Died p*

<table>
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<tr>
<td>Standard BE</td>
<td>1.2 ± 1.0</td>
</tr>
<tr>
<td>Na–Cl</td>
<td>3.5 ± 0.8</td>
</tr>
<tr>
<td>Alb</td>
<td>2.7 ± 0.2</td>
</tr>
<tr>
<td>UIC</td>
<td>-4.9 ± 0.9</td>
</tr>
</tbody>
</table>

NS – Not significant; *Student t-test.

Conclusions: The standard BE and UIC of the standard BE may be predictable for mortality in critically ill septic patients. Results of our study, conducted on patients with the mean risk of death 41.5%, confirmed the earlier observations (1,2). To assess the proper predictive value of UIC in the patients with the different risk of death the further studies are needed.

References:

Acknowledgement: Supported by KBN 3 POZ 109 24.

A-639
First year experience of APACHE II scoring in intensive care and high dependency care units in St Lukes Hospital, Malta
M. Galea Scannura, E. Grech, A. Gera
Department of Anaesthesiology, Southampton General Hospital, Southampton, United Kingdom

Background and Goal of Study: APACHE II scoring is widely used to assess quality of care in intensive care, and to compare performance of different units (1). The aim of the study was introduce ongoing APACHE II scoring and standardised mortality ratio (SMR) calculation in the intensive care and high dependency care unit (ITU/HDU) at St Luke's Hospital, Malta; and to provide baselines against which the performance of future years can be measured.

Materials and Methods: A prospective, consecutive, non-interventional study was carried out over 4 months. Physiological variables were collected at the bedside by the same two people (2). Admission and outcome data was also collected. APACHE II score, predicted mortality and SMR were then calculated retrospectively. One patient was excluded because of missing variables; children less than 16 years old and burns patients were also excluded.

Results and Discussions: 251 patients were included – 106 medical and 145 surgical patients. The SMR for the whole unit (ITU and HDU) was 0.74. Overall performance for surgical patients was better than for medical patients (SMR medical 0.83; surgical 0.60). A trend to worse outcome in older age groups was also observed, with the worst being 60–69 age group (SMR 0.88).

Conclusions: Total ITU/HDU performance was better than expected, with all values being less than 1. The SMR of the unit (0.74) can be used as a baseline for future years. The study also indicates a need to investigate subgroups of patients who need increased attention, with the aim to improve outcome.

APACHE II scoring is now being done daily for all patients. The plan is to repeat the study comparing outcomes of A&E admissions with ward admissions; and excluding elective post-operative surgical admissions.

References:

A-640
Validity and reliability of the Turkish version of confusion assessment method for the intensive care unit (CAM-ICU)
S.B. Akinci, M. Rezaki, H. Ozdemir, A. Celikcan, M. Kanbak, K. Yorganci, U. Aypar
Department of Anaesthesiology and Reanimation, Hacettepe University Faculty of Medicine, Ankara, Turkey

Background and Goal of Study: Delirium is a serious problem, common in the intensive care units (ICU), and can cause significant morbidity and mortality, if unrecognized and untreated. Diagnostic instruments for delirium should be developed and the ICU personnel should be educated. This study aimed to evaluate the reliability and validity of Turkish version of CAM-ICU (YBU-KDO) to identify delirium in the ICU patients.

Materials and Methods: 60 patients, who stayed in the ICU >48 hours, were included into our study. The ICU nurse and the intensivist performed independent YBU-KDO ratings. YBU-KDO has four features: an acute onset of mental status changes or fluctuating course, inattention, disorganized thinking and an altered level of consciousness. The patient is diagnosed as delirious with the first two features and either feature 3 or 4. A psychiatrist interviewed the patient and the family members to assess for delirium. T-test, chi-square test and Kappa tests were used for statistical analysis.

Results and Discussions: The mean ± SD of weight and APACHE II score on admission were 72 ± 15 and 18 ± 8. 29 patients were male. Delirium was diagnosed in 26(43%) patients. The delirious patients were older (83 ± 17 years), more commonly had previous ICU stay (54%), emergency admission (100%) and stayed in the ICU longer (12 ± 19 days) compared to non-delirious patients (51 ± 19 yrs, 18%, 62%, 4 ± 2 days, respectively). In YBU-KDO only verbal attention test was applied to test the inattention and increasing the cut-off value from 8 to 12 increased the agreement. This form of YBU-KDO had acceptable sensitivity (65-69%), excellent specificity (97%) and reliability (kappa = 0.96).

Conclusion: We think inclusion of YBU-KDO into daily charts would allow early diagnosis, implementation of preventive measures and the treatment of delirium in the ICU.

Reference:

A-641
Mild therapeutic hypothermia – pitfalls and pearls
M. Busch, E. Søreide
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Background and Goal of Study: Mild therapeutic hypothermia improves neurological recovery after prehospital cardiac arrest (1) and has become a standard procedure in postresuscitative care. Our goal was to study the complications during MIH (2).

Materials and Methods: We evaluated retrospectively 30 patients with VF-OHCA with regard to complications associated with the use of MIH. MIH was accomplished by a surface cooling protocol and maintained for 12–24 hours. Complications during MIH were recorded. MIH complications were defined as any complications during MIH that required intervention or treatment. MIH complications were classified as early complications (0–4 hours) and late complications (4–12 hours) in MIH. The study was carried out in Rogaland Central Hospital during 2000–2002.

Results: MIH complications were noted in 26 (86.7%) patients. MIH complications included: infused cold blood transfusions (10%), hypotension with vasopressor requirement (10%), hypothermia (4.9%) and hyperventilation (3.9%). MIH complications during MIH were not associated with VF-OHCA survival (p = 0.71). MIH complications during MIH were not associated with MIH complications during MIH (p = 0.81).

Conclusions: MIH complications were noted in 26 (86.7%) patients. MIH complications included: infused cold blood transfusions (10%), hypotension with vasopressor requirement (10%), hypothermia (4.9%) and hyperventilation (3.9%). MIH complications during MIH were not associated with VF-OHCA survival (p = 0.71). MIH complications during MIH were not associated with MIH complications during MIH (p = 0.81).

Reference:
**Results and Discussions:** Median age of the patients was 60.5 years (32–75 years) with all patients (100%) having presumed cardiac cause of OHCA and ventricular fibrillation (VF) as the initial ECG-rhythm. All patients (100%) were intubated at the scene.

Complication | Incidence in %
--- | ---
Hyponatremia | 73.3 (n = 22)
Severe hyponatremia (< 3.0 mmol/l) | 36.6 (n = 11)
Pneumonia | 70 (n = 21)
Elevated amylase | 53.3 (n = 16)
Antrhymia | 23.3 (n = 7)
Elevated INR (1.3–1.5) | 16.6 (n = 5)
Platelet reduction > 30% | 10 (n = 3)
Insulin resistance | 16.6 (n = 5)
Hyperkalemia during rewarming | 3.3 (n = 1)
Hemorrhage | 0
Pancreatitis | 0
Thrombocytopenia | 0
Leukocytopenia | 0

**Conclusion(s):** MIH is a safe therapy when the clinician is aware of the potential side effects. Electrolyte-disorders and pneumonia should be anticipated and treated preemptively.

**References:**

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**A-642**

**Bacterial flora isolated in septic patients with gunshot injury**

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*Aesthesia and Intensive Care Unit, Trauma Center – Central Military University Hospital, Tirana, Albania*

**Background and Goal:** Gunshot wounds get contaminated since the beginning from the exogenous or endogenous flora of the injured person.

**Materials and Methods:** From 314 patients with gunshot injury admitted in intensive care, 85 of them or 27.07% manifested the symptoms of sepsis, whereas 21 of them or 24.7% have displayed a clinical framework of the septic shock. Average age 43 years of age, 71 M & 14 F.

**Results and Discussions:** Spearman’s rank correlation test revealed a significant positive correlation between the total bacterial flora and the number of infections (P < 0.05). The VAP (Ventilator Associated Pneumonia) group had the highest level of flora compared to the non-VAP group. The most prevalent were E. coli, Klebsiella, Enterococcus, Staphylococcus, and Pseudomonas. The flora distribution varied significantly between the groups. The examination of the flora isolated from the VAP patients revealed a predominance of gram-negative bacteria, while the non-VAP group showed a higher proportion of gram-positive cocci. The flora isolated from the VAP group included E. coli, Klebsiella, Pseudomonas, and Enterococcus, while the non-VAP group showed a predominance of Staphylococcus, Enterococcus, and Pseudomonas.

**Conclusion(s):** This study highlights the importance of early identification and targeted antimicrobial therapy in patients with gunshot injury to prevent sepsis and reduce morbidity and mortality.

**References:**

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**A-644**

**Influence of different ways of alimentary therapy on selected serum lipids in sepsis**

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*Department of Intensive Care and Pain Clinic, Karol Marcinkowski University of Medical Sciences, Poznań, Poland*

**Background and Goal of Study:** Sepsis is accompanied by metabolic disorders which lead to several changes in serum concentration of lipids. The crucial element in the treatment of sepsis patients is alimentary therapy. The aim of the study is to assess the dynamics of selected lipids in sepsis patients related to the applied alimentary therapy.

**Materials and Methods:** Thirty patients (aged 18–60) entered the study, who were randomly chosen to form two groups, 15 patients each. In group I, for 10 days, patients received a full balanced parenteral diet according to the AIJo system. In group II patients were put on an enteral diet. Fifteen patients served as controls. On the 1st, 4th and 10th day of therapy FFA was studied in the two groups. We found Nadroparine easier to manipulate. There was no significant difference in average circuit life among the two groups. We found Nadroparine easier to manipulate because no anticoagulation monitoring is needed. The patients had no sign of bleeding.

**References:**

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**A-645**

**Assessment of simple vs double transpulmonary thermomodulation**

B. Rossignol, G. Kiss, G. Gueret, C.C.A. Arvieux

*Department of Anesthesiology, CHU, Brest, France*

**Background and Goal of Study:** Hemodynamic monitoring is essential for the management of the critically ill patients. Transpulmonary double
dilution (DT) is the gold standard to measure intrathoracic volumes. PICCO system calculate indexed intrathoracic blood volume (ITBVI), global end diastolic blood volume (GEDVI), extravascular lung water (EVLWI) and measure cardiac index (CI) with transpulmonary single dilution (ST). We prospectively studied the agreement between ST and DT transpulmonary measurements of cardiac output and intrathoracic blood volumes.

Materials and Methods: All patients who need invasive hemodynamic investigation were included in the study. ST and DT were prospectively compared using the Pulsion Picco and the Pulsion Cold Z-021 monitor respectively. The relations between ITBVI, GEDVI, CI, EVLWI were compared between both techniques. Correlation between variables were analysed by linear regression. Bland-Altman analysis was used to compare the agreement among the different methods. P < 0.05 was considered as significant.

Results and Discussions: 50 matched sets of IC, ITBVI, GEDVI, measurements between ST and DT were collected in 15 critical ill patients. A significant relation between IC, ITBVI, GEDVI, EVLWI does exist. The means differences in measurements (ST-DT) are resumed in table 1.

<table>
<thead>
<tr>
<th></th>
<th>Bias</th>
<th>2 DS</th>
<th>2 DS</th>
<th>(r^2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>IC</td>
<td>-0.5</td>
<td>0.7</td>
<td>-1.8</td>
<td>0.56</td>
</tr>
<tr>
<td>ITBVI</td>
<td>-184</td>
<td>76</td>
<td>-444</td>
<td>0.65</td>
</tr>
<tr>
<td>GEDVI</td>
<td>-8</td>
<td>320</td>
<td>-1096</td>
<td>0.69</td>
</tr>
<tr>
<td>EVLWI</td>
<td>-9</td>
<td>7</td>
<td>-24</td>
<td>0.93</td>
</tr>
</tbody>
</table>

However EVLWi is overestimated EWLWi at low normal value and underestimated at higher values.

Conclusion(s): Parameters derived from the simple thermodilution obtain by the PICCO system do not allow a real assessment of left ventricular preload and pulmonary blood volume in the extreme values.

A-646

Is JPP a good indicator of preload in ICU? B. Rossignol, G. Gueret, G. Kiss, C.C.A. Anieux Department of Anaesthesiology, CHU, Brest, France

Background and Goal of Study: Assessment of cardiac preload is of major importance for the management of critically ill patients. Left ventricular end-diastolic area (LVEDA) can be determined with transesophageal echocardiography. Intrathoracic blood volume index (ITBVI), global end diastolic volume index (GEDVI), and presentation of pressure pulse (JPP) during mechanical ventilation are used as surrogates for cardiac preload. The objective of our study was to find out if there is a correlation between these different parameters in order to determine preload at any given moment during resuscitation.

Materials and Methods: Following haemodynamic data were obtained from transpulmonary thermodilution with the double dilution technique (cold Pulsion): ITBVI, GEDVI, cardiac index CI. LVEDA was measured using the transgastric short-axis view, and JPP was determined from changes in peripheral pulse pressure during the respiratory cycles. The relationship between JPP and respectively ITBVI, GEDVI, CI, and LVEDA was analysed and discriminated by various ranges of CI (< or = 3.0 and >3.0/min/m²) within patients. The correlations between variables were also analyzed by linear regression analysis. P < 0.05 was considered as significant.

Results and Discussions: 15 patients were included into the study. Overall 50 measurements were performed. Correlations between ITBVI, GEDVI, LVEDA and JPP were moderate \(r^2 = 0.47, 0.46, 0.43\) respectively. No correlation was observed between JPP and other values within ranges of CI < 3l/min/m². However the relationship was significant with a CI > 3l/min/m² \(p < 0.05, r^2 = 0.60, 0.66, 0.43\) respectively.

Conclusion: JPP is not reliable enough to evaluate preload in patients with low CI.

A-647

Prophylaxis with granulocyte colony-stimulating factor improves the outcome of high-risk colorectal cancer patients with lowered postoperative body temperature A. Torossian, W. Lorenz, B. Stinther, H. Wulf, A. Bauhofer Department of Anaesthesiology and Critical Care, University Hospital Marburg, Marburg, Germany

Background and Goal of Study: Perioperative hypothermia is a risk factor after major surgery (1). Previously we have shown that prophylaxis with granulocyte colony-stimulating factor (G-CSF) improves the outcome of hypothermic septic rats (2). In a clinical trial we now explored whether G-CSF prophylaxis may improve recovery especially in high-risk patients with lower body temperature after colorectal cancer surgery.

Materials and Methods: After ethical approval 80 patients (ASA class 3&4) undergoing colorectal cancer surgery were randomized to: 1) G-CSF + cefoxorime/metronidazole (G/cef-met), 2) G-CSF + oxefoxicin/metronidazole (G/off-met), 3) placebo + cef-met or 4) placebo + off-met. G-CSF was given s.c. 12h prior and 32 and 36h after surgery. All patients were warmed and their core temperature recorded intraoperatively. Primary endpoints were patients quality of life, complication rate and length of stay, secondary immunological parameters (granulocyte phagocytosis, cytokine release, HLA-DR expression).

Results: The G-CSF patients tended to have lower postoperative body temperatures: 35.0 vs. 35.3, \(p = 0.16\). However, G-CSF improved the phagocytic capacity of granulocytes and the HLA-DR expression on macrophages (G-CSF + cef-met vs. placebo \(p = 0.04\) and \(p = 0.03\)). Patients with a greater temperature decrease had a higher TNF-alpha; release on the 3rd postoperative day \(\Delta p = 0.2\) and lower IL-18 levels \((450\text{pg/mL} \pm 241\text{pg/mL}, \Delta p = 0.01)\).

The patients with G-cef had fewest postoperative complications \((16\% \text{ vs.} 53\%, 40\% \text{ and } 45\%, \Delta p = 0.01\) and the shortest length of stay \((12 \text{ vs.} 13, 13.5 \text{ and } 14\text{ days}, \Delta p = 0.01)\). Furthermore they reached the best quality of life at discharge \((60 \pm 23\% \text{ points}, \Delta p = 0.1)\).

Conclusions: Although the patients with G-CSF tended to lower body temperature after surgery than those with placebo, their overall postoperative restitution was better. This might be due to an enhanced number and phagocytic activity of granulocytes. The role of IL-18 with regard to postoperative complications needs further evaluation.

References:

A-648

Evaluation of single intensive care unit performance in Croatia using APACHE II and SAPS II systems K. Desa, Z. Zupan, B. Krstulovic, V. Golubovic, A. Sustic Clinic of Anaesthesiology and Intensive Care, University hospital Rijeka, Rijeka, Croatia

Background and Goal of Study: To evaluate intensive care unit performance using: Acute physiology and chronic health evaluation II (APACHE II) and Simplified acute physiology score II (SAPS II) in a single University hospital in Croatia.

Materials and Methods: We prospectively observed 395 patients without younger than 16 years old, burned, heart surgery patients and patients whose length of stay in ICU was less than 4 hours. Predicted mortality for every patient and standardized mortality ratio (SMR) for hospital and ICU was calculated. Predictive value of scoring systems was evaluated with discrimination and calibration measures.

Results and Discussions: Hospital SMR is high (APACHE II = 1.58; SAPS II = 1.60). SMR in the ICU is on the upper margin of SMRs in the literature which is indicative for high hospital departments mortality because high dependence rooms lack. Both evaluated scoring systems had good discrimination power as expressed by area under receiver operating characteristics curve (APACHE II = 0.821 and SAPS II = 0.827), but their calibration was less perfect ( Hosmer-Lemoshow – APACHE II: \(C = 17.473; df = 8\); \(p = 0.026\) and SPAS II: \(C = 22.961; df = 8\); \(p = 0.003\)) Elective patients had higher proportion and lower predicted and observed mortality than the emergency or medical patients. There are no major differences between the last two groups in the predicted and observed mortality.

Conclusion(s): It is necessary to perform customisation of scoring systems. There are no major differences between scoring systems. Quality of care in our hospital is worse than in original reports which requires further analysis.

References:

A-649

Outcome measured by mortality and length of stay in a surgical intensive care F.J. Abellh, N.M. Landeiro, A.M. Neves, C.C. Santos, M.A. Castro Department of Anaesthesiology and Intensive Care, Hospital de São João, Porto, Portugal

Background and Goal of Study: Predictions of outcome, measured by length of stay (LOS) and mortality, can assist in planning and optimize intensive care facilities and utilization. The aim of this study was to evaluate predictive factors for in-hospital outcome in patients admitted to a surgical ICU.

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Materials and Methods: All 185 adult patients who underwent scheduled or emergency noncardiac surgery admitted to a surgical ICU between April and July 2004. The variables prospectively recorded were: social demographics data, core temperature (Tc) measured before surgery, on arrival on ICU, and every two hours until 6 hours after admission, ASA physical status, emergency or scheduled surgery, magnitude of surgical procedure, anesthesi-athena technique, amount of fluids during anesthesia, use of temperature monitoring and warming techniques, duration of the anesthesia, LOS in ICU and in the hospital and SAPS II score. Assessment of the relationship between each clinical variable and long ICU stay or mortality was made using uni-variant analysis performed by simple binary logistic regression with an odds ratio (OR) and its 95% confidence interval (95%CI).

Results and Discussion: Mean LOS in the ICU was 4.09 ± 10.23 days. 20% of patients stayed longer than 3 days in ICU. Significant risk factors for staying longer in ICU were SAPS II (OR 1.13, 95%CI 1.06–1.17, p < 0.001), ASA (OR 4.76, 95%CI 1.87–12.10, p = 0.001 for ASA III/IV patients), amount of colloid (OR 4.95, 95%CI 1.51–16.21, p = 0.018), plasma (OR 1.84, 95%CI 1.16–2.90, p = 0.009) and blood (OR 1.31, 95%CI 1.01–1.69, p = 0.039) used during surgery. Fourteen (7.6%) patients died in ICU and 29 (15.7%) died during their hospitalization. Statistically significant independent risk factors for mortality were emergency surgery (OR 7.11, 95%CI 2.90–17.42, p < 0.001), major surgery (OR 5.50, 95% CI 1.13–26.69, p = 0.034), high SAPS II scores (OR 1.11, 95% CI 1.07–1.14, p < 0.001), longer stay in ICU (OR 14.57, 95% CI 5.87–37.18, p < 0.001 for LOS longer than 3 days) and in the hospital (OR 1.02, 95%CI 1.01–1.04, p < 0.001).

Conclusions: Prolonged ICU stay is more frequent in more severe patients at admission and it is associated with higher hospital mortality that is also more frequent in patients submitted to emergent surgery and major surgery.

A-650
Acute renal failure after cardiac surgery 2004 versus 2002
M. Luchian, D. Filipescu, I. Raileanu, M. Cristea, O. Ghenu, L. Iliuta, D. Tulbure
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Background: Acute renal failure (ARF) requiring renal replacement therapy (RRT) after cardiac surgery remains a cause of major morbidity and mortal-

ity (1). Our objective is to assess the incidence and outcome of ARF after car-
diac surgery with cardiopulmonary bypass (CPB) in 2004 compared to 2002.

Methods: We compared retrospectively demographic and perioperative data in consecutive adult patients undergoing cardiac surgery with CPB in 2002 (544 patients) and 2004 (276 patients). ARF was defined as a rise in serum creatinine above 120 μmol/l or twofold rise of baseline value. RRT was indicated on clinical and biological grounds. Data are expressed as mean ± SD. Continuous variables were analyzed with unpaired t-test. Categorical variable were compared by Fisher’s exact tests and a P-value of <0.05 was considered significant.

Results: There is no difference regarding demographic, perioperative fac-
tors and type of surgery in the two groups. In 2004, 7.6% of patients devel-
oped ARF after cardiac surgery with CPB compared to 11.9% in 2002 (p = 0.0027). 3.7% of all patients required RRT in 2002 vs. 1.4% in 2004 (p = 0.029). In-hospital mortality in ARF patients decreased between the two periods of time: 20% in 2002 vs. 4.8% in 2004 (p = 0.015). There is no statistical difference regarding in-hospital mortality in ARF patients requiring RRT: 52.4% in 2002 vs. 25% in 2004 (p = 0.23). Higher percentage of patients received aprotinin (38% vs. 21%, p < 0.001), metilprednisolon and intraoperative hemofiltration) may be involved in decreasing the incidence of ARF in cardiac surgery. Reference: 1 Mangano C.M. et al. Ann Intern Med 1998; 128 (3): 194-203.

A-652
Radical surgery for esophageal cancer: our experience and analysis of risk factors for perioperative mortality
V. Karadzic, T. Kromar, J. Spicic Macan, J. Kogler, V. Majeric Kogler
Department of Anaesthesiology and Intensive Care, University Hospital for Chest Diseases Jordanovac, Zagreb, Croatia

Background and Goal of Study: Radical operative therapy for esophageal cancer is usually connected with a significant mortality and morbidity (1). Purpose of this study is analysis of potential risk factors for mortality after radical surgery for esophageal cancer and presentation of our experience with this kind of surgery.

Materials and Methods: There were 65 patients undergone radical surgery for esophageal cancer from the June 2003 to the April 2004. In our University hospital for chest diseases. We analyzed as mortality risk factors: sex, age, albumin, aspartate transaminase, alanine transaminase, gamma glutamyl transferase, creatinine, hemoglobin, leucocytes, fibrinogene, pro-thrombine time, activated partial thromboplastine time, forced expiratory volume in the first second, vital pulmonary capacity, diffusion capacity for carbon monoxide (all preoperative), duration of surgery, perioperative infused fluid volume, perioperative transfusion, duration of stay in the ICU.

Results and Discussions: In our study perioperative mortality was 15.3%. Incidence of complications: pulmonary 44.61%, cardiac 6.15%, and surgical 27.69%. There were no statistically significant differences between groups of patients connected with most of analyzed factors. The most important finding is positive correlation of level of gamma glutamyl transferase with perioperative mortality (Fisher p = 0.012 for gamma glutamyl trasferase >38 U/L, and Fisher p = 0.017 for gamma glutamyl transferase >76 U/L – Fishers x 2 test).

Conclusion(s): Among the analyzed factors, only factor of potential prog-
ostic importance for patients undergoing radical surgery for esophageal cancer could be the level of gamma glutamyl trasferase.


A-653
EUROscore and cost of ICU stay after cardiac surgery
P. Knapik, D. Ciesla, M. Knapik, P. Nadziakiewicz, M. Zembala
Department of Cardiac Anaesthetics, Silesian Centre for Heart Diseases, Zabrze, Poland

Background and Goal of Study: EUROscore (ES) is a commonly accepted scale to assess the operative risk of cardiac surgical patients. The most expensive part of cardiac surgical procedure is connected with ICU stay. It seems to be obvious that the cost of ICU stay should be linked to the preoperative ES, but these relations were not explored previously. The aim of this study was to compare total cost and length of ICU stay in patients with various ranges of preoperative ES.

Materials and Methods: Individual cost of ICU stay of 1265 consecutive adult patients who underwent cardiac surgery was calculated over the 10 months period. Individual data for each patient were extracted from hospital laboratory, X-ray department, magazine, pharmacy and blood bank and then added, creating total cost of ICU stay for each individual patient. Salaries of the ICU personnel and media were not included. Local currency (polish zloty) was converted to Euro to enable comparisons to other European countries (exchange rate for 13.12.2004). Length of ICU stay for each patient was extracted from the database and cost of 24 hours of ICU stay was calculated. Descriptive statistics, ANOVA and Pearson’s correla-
tion were used. p < 0.05 was considered significant. Data are expressed as mean ± SEM.

Results: Correlation of individual cost of ICU stay versus individual ES for each patient was on the borderline of statistical significance (r = 0.3, p < 0.01).

<table>
<thead>
<tr>
<th>ES</th>
<th>No of pts</th>
<th>% of pts</th>
<th>ICU stay (hours)</th>
<th>Mean total cost (Euro)</th>
<th>Mean daily cost (Euro)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–2</td>
<td>335</td>
<td>27%</td>
<td>30 ± 2</td>
<td>174 ± 12</td>
<td>144 ± 2</td>
</tr>
<tr>
<td>3–5</td>
<td>526</td>
<td>42%</td>
<td>40 ± 3</td>
<td>253 ± 18</td>
<td>148 ± 3</td>
</tr>
<tr>
<td>6+</td>
<td>403</td>
<td>32%</td>
<td>68 ± 5</td>
<td>477 ± 39</td>
<td>116 ± 6</td>
</tr>
</tbody>
</table>

(p < 0.05)

Duration of ICU stay, mean total ICU cost and mean daily ICU cost stay was not different between 0–2 and 3–5 ES ranges. Patients with ES > 6 spent more time in ICU and their daily cost was also higher – all differences were statistically significant towards groups with lower ES ranges.

Conclusion(s): Patients with ES 0–2 and 3–5 have similar length of ICU stay and generate similar cost. Patients with ES > 6 stay longer on the ICU and their stay is significantly more expensive.

A-654
Is it important to assess patients satisfaction in ICU?
D. Ionescu, L. Vele, D. Miclea, D. Ariesan
Department of Anesthesia and Intensive Care, University of Medicine and Pharmacy, Cluj-Napoca, Romania

Background and Goal of Study: The investigation of the sources of patients’ satisfaction and discomfort in the intensive care unit is still an...
actual problem and should be done periodically. The aim of our study was to evaluate patients’ satisfaction and to detect possible sources of discomfort based on an original questionnaire, taking in consideration the problems and the specific of our surgical intensive care unit.

Materials and Methods: 207 patients admitted in ICU (between January 2004–October 2004) were included in the study after obtaining the informed consent. They have filled in the questionnaire during the first 24 h after their discharge from ICU.

Results and Discussions: The first four main sources of discomfort were pain (120 patients, 57.9%), anxiety (88 patients, 42.51%), hunger and thirst (87 patients, 42.47%) and insomnia (82 patients, 39.61%). Immobilization, noise, venous punctures were other important sources of stress and discomfort.

On the other side, for 78.7% of the patients, the quality of the staff care was the most impressing. All patients who were asking for help to solve their problems received it properly care.

Conclusion: It is important to assess patients’ satisfaction in ICU because from such questionnaire we can identify the main sources of discomfort and we can take the necessary measures to diminish these sources. Moreover we consider it is important to have such assessments periodically in order to keep stuff attention awake of these sources of discomfort.

References:

A-655
Role of systemic inflammatory response in acute renal dysfunction after cardiac surgery with cardiopulmonary bypass
G. Gueret, B. Rossignol, G. Kiss, F. Lion, T. Nimai, C.C. Arvieux
Department of Anesthesiology, University Hospital, Brest, France
Background: The pathophysiology of acute renal dysfunction (ARD) after on-pump cardiac surgery still remains under discussion. However, it is known that systemic inflammatory response increases after cardiopulmonary bypass (CPB)1. The aim of this study was to evaluate the role of the systemic proinflammatory response in ARD occurring after on-pump cardiac surgery.

Material and Methods: After informed consent, 62 patients scheduled for cardiac surgery with CPB were prospectively included. Plasmatic C-reactive protein (CRP), TNF and IL 6 levels were measured respectively before (T0), 30 min after the start of CPB (T1), at the end of CPB (T2), on ICU arrival (T3) and on day 1 (T4) and day 2 (T5) after surgery. ARD was defined as a 25% increase of the serum creatinine level. Data were compared with ANOVA and as follows: C vs UV/P. Data were compared with regression analyses. p < 0.05 was considered as significant.

Results: For urinary collection times below 400 min, the difference between both methods varies greatly (table 1).

Conclusion: Creatinine clearance is unreliable for evaluating renal function in on-pump cardiac surgery for urinary collection times below 400 min. The Cockcroft method seems to be more accurate because it does not depend on the quality of urinary collection.

Reference:

A-657
Severe outbreak of multidrug-resistant Acinetobacter Baumannii in neoplastic intensive care unit: clinical and genetic characteristics
Department of Anesthesia, Analgesia, and Intensive Care, Anesthesia and Reanimation, Naples, Italy
Background and Goal of Study: The rapid emergence of multidrug-resistant Acinetobacter baumannii (Acb) was observed in a tertiary care teaching hospital in Naples (Italy). We studied the clinical characteristics and genetic epidemiology of this infection.

Materials and Methods: From June 2003 to July 2004, Acb was isolated from 75 patients in the cardiorespiratory intensive care unit. SAPS II and SOFA scores were calculated at admission and at the time of Acb isolation. Genotype analysis by Apal digestion and pulsed field gel electrophoresis (PFGE) was performed in twenty multiresistant Acb isolates.

Results and Discussions: 92% of the Acb isolates showed a multidrug-resistant (MDR) phenotype, including ampicillin-sulbactam, carbapenems and aminoglycosides, but were susceptible to colistin. Acb was responsible for 39 infections and 36 colorizations. 19 patients showed the presence of the Acb at the hospital admission, while in 56 it was isolated during the hospitalization. 37 patients had a ventilator-associated pneumonia. Genotype analysis showed the same macrorestriction PFGE pattern. This profile was identical to that of an epidemic Acb clone previously isolated in a different ICU in Naples. Type 1 integron of 2.2 kb was amplified from the chromosomal DNA of all multiresistant Acb clones isolated. Sequence analysis of the integron showed the presence of three gene cassettes: aacA4, which confers resistance to amikacin, netilmicin, and tobramycin; an unknown ORF, and blaOXA-23. Which confers resistance to amoxicillin, ticarcillin, oxacillin, and cloxacin and carbapenems. Crude mortality was 60%. On the basis of the
A-658
Limitations of central venous pressure and peripheral venous pressure agreement in intensive care unit patients
S.B. Akinci, A. Salman, M. Kanbak, G. Bagceci, U. Ayvar
Department of Anesthesiology and Reanimation, Hacettepe University Faculty of Medicine, Ankara, Turkey
Background and Goal of Study: Measuring peripheral venous pressures (PVP) through peripherally inserted cannulae might be an alternative to measuring central venous pressures (CVP) (1). Our aim was to determine the agreement between CVP and PVP measurements in critically ill patients and to define a subgroup of patients in which CVP can be used interchangeably with PVP.

Materials and Methods: 24 hour simultaneous paired PVP and CVP measurements were recorded from 41 critically ill patients with a central venous catheter and a peripheral venous catheter on the dorsum of the hand. The range of agreement was defined as mean bias ± 2SDc (corrected standard deviation for repeated measurements from same individuals) as described by Bland and Altman (2). According to this approach patients were divided into two groups; good agreement group, poor agreement group. χ²-test, Mann-Whitney-U tests were used to compare the two groups.

Results and Discussions: In 94 (> 10%) measurements pairs the biases were outside the ±2SDc limits of agreement. There were no difference between the two groups regarding vital functions and total fluid balance during 24 hours of measurements.

CVP-PVP Agreement

<table>
<thead>
<tr>
<th></th>
<th>Good (n = 15)</th>
<th>Poor (n = 26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years) (mean ± SD)</td>
<td>42 ± 25</td>
<td>37 ± 24</td>
</tr>
<tr>
<td>Male/Female</td>
<td>7/8</td>
<td>8/16</td>
</tr>
<tr>
<td>APACHE II score</td>
<td>18 ± 8</td>
<td>16 ± 9</td>
</tr>
<tr>
<td>Admission diagnosis</td>
<td>10²/4,3/1</td>
<td>1/19/3/3</td>
</tr>
<tr>
<td>Postoperative patients</td>
<td>12</td>
<td>22</td>
</tr>
<tr>
<td>Patients requiring mechanical ventilation</td>
<td>14</td>
<td>20</td>
</tr>
<tr>
<td>Bias between CVP and PVP</td>
<td>7 ± 2</td>
<td>7 ± 5</td>
</tr>
<tr>
<td>Measurements pairs with disagreement</td>
<td>0/0 (0)</td>
<td>21/10¹</td>
</tr>
</tbody>
</table>

*P < 0.05 between the two groups

Conclusion(s): PVP measurements might be an alternative to CVP measurements only in a selected group of ICU patients with respiratory problems but without hemodynamic instability.

References:

A-661
Hypokaliaemia and hypomagnesemia during acute coronary syndrome
E. Taneva
Department of cardiology, Intensive Care, University Hospital “Alexandrovskaja”, Sofia, Bulgaria
Background and Goal: The serum level of Potassium (K⁺) is routinely investigated while the serum level of Magnesium (Mg²⁺) is ignored. The aim of this study is to register the serum level of K⁺ and Mg²⁺ in dynamics in patients with acute coronary syndrome (ACS).

Material and Methods: The study includes 25 patients, 8 women and 17 men at the average age of 59 years (from 36 to 85 years). 16 patients have Acute Myocardial Infarction (AMI) and 9 are with unstable angina. The samples are taken at 3 stages: 1. till the 6-th hour from registration 2. at 24-th hour and 3. at the 3-rd day. The substitution is made with Kalium-Magnesium asparginat (Panangin – Gedeon-Richter) at the 48-th hour intravenously. After that throught the mouth. The correlation between the serum levels of K⁺ and Mg²⁺ at the different stage is investigated.

Results: 80% of patients in I-stage have hypokaliaemia at average of 3,15 mmol/l (from 2,3 to 3,3 mmol/l) and 28,98% of them have hypomagnesemia.

A-662
Effect of hyperbaric oxygen treatment on the serum malondialdehyde levels in the experimental CO poisoning
M. Oszos, S. Pocan, M. Gokben, T. Ozkilic, C. Tutuncu, S. Ozkan
Department of Anesthesiology & Reanimation, Gata Haydarpasa Training Hospital, Istanbul, Turkey
Background and Goal of Study: We intended to research the changes in serum malondialdehyde (MDA) levels in experimental acute carbon monoxide (CO) poisoning and the effect of different oxygen treatment protocols.

Material & Methods: Sixty Sprague Dawley rats were separated randomly into 6 groups. CO in 2000 ppm concentration was applied for one hour to Groups I, II, and III, for two hours to Group IV, V, VI. After the poisoning procedure, 100% HBO₂ for 1–1.5 hours was applied to Group I and IV, 2ATA 100% HBO₂ for 1–1.5 hours to Group II and IV and 3ATA 100% HBO₂ for 1–1.5 hours to Group III and VI respectively. For the measurements of COHb and replications) via headaches during a steady state propofol effect site concentra-

Downloaded from https://www.cambridge.org/core. IP address: 35.160.27.221, on 21 Apr 2022 at 00:03:23, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/S0265021505001341
MDA levels, 1.5 ml blood samples were taken in pre-poisoning (C1-M1), post-poisoning (C2-M2) periods, after treatment (C3-M3) and after 24 hours (C4-M4).

Results and Discussion: In all groups, COHb levels were increased after CO poisoning at C2 (p < 0.001). They dropped to 2%, 1% respectively after different treatment protocols. However, the increase in MDA levels continued at C4-M4 in all groups. At M4 while MDA levels of 100% HBO2 and 3ATA HBO2 groups were significantly high (p < 0.05) compared to control (M1) values, MDA levels of 3ATA HBO2 group decreased to control values.

Conclusion: Serum MDA levels could be used as a marker, pointing the severity of lipid peroxidation and the effectiveness of treatment protocols (1). It was also concluded that following the serum MDA levels were important in determining the severity of early and late neurological sequells and among the oxygen treatment protocols for lowering MDA levels, improving oxidative stress, 3 ATA 100% HBO2 for 1.5 hour was the most effective modality.

Reference:

A-663
Increased superoxide production after intermittent pringle maneuver
Department of Anesthesiology and Pain Medicine, Kyungpook National University, Daegu, Republic of Korea

Background and Goal of Study: The Pringle maneuver (PM), hepatic inflow occlusion, during hepatic surgery reduces intraoperative bleeding and blood transfusion requirement (1), but hepatic ischemia/reperfusion injury (IRI) is inevitable. Xanthine oxidase (XO) can serve as a critical source of ROS that contribute to inflammatory signaling, IRI and impaired vascular function (2,3). The authors followed changes of plasma XO activity and superoxide production during hepatic surgery under PM and the influence of XO on endothelium-dependent vascular relaxation.

Materials and Methods: Eleven patients that underwent heptectomy under intermittent PM were studied. Blood was withdrawn before PM and 20 minutes after final reperfusion. Plasma XO activity was measured using a spectrophotometer. Superoxide production was measured by cytochrome c reduction by plasma XO. The influence of XO on endothelium-dependent relaxation was assessed in isolated rat aortic ring segments, which were incubated with/without XO. NADH was added 15 min before isometric tension measurements as a substrate.

Results and Discussion: After final reperfusion, plasma XO activity had increased four-fold with a concomitant increase in superoxide production. The XO + NADH-dependent inhibition of vascular relaxation was reversible by addition of CuZn SOD.

Conclusion(s): Significantly more XO is released into the systemic circulation after intermittent PM, with subsequently increased superoxide production. The impaired nitric oxide bioavailability by the XO-induced superoxide after intermittent PM indicates hepatic surgery under PM might be beneficially managed using antioxidative drugs or anesthetics with a known antioxidative effect.

References:

A-664
Evaluation of central vein catheter thrombosis in ICU patients
M. Bahar, A. Ekinci, I. Haci, D. Egeli
Department of General Intensive Care Unit, VKV American Hospital, Nisantasi, Turkey

Background and Goals: Asymptomatic catheter-related central vein thrombosis (CVT) which is diagnosed by venographic studies is mentioned to be as high as 66%. Moreover, when thrombosis occurred, the risk of catheter related sepsis was declared to be 2.6% higher. In this prospective study we aimed to diagnose CVT early as possible, its incidence and risk factors.

Material and Methods: ICU patients that needed a central venous access under intermittent PM were studied. Blood was withdrawn before PM and 20 minutes after final reperfusion. Plasma XO activity was measured using a spectrophotometer. Superoxide production was measured by cytochrome c reduction by plasma XO. The influence of XO on endothelium-dependent relaxation was assessed in isolated rat aortic ring segments, which were incubated with/without XO. NADH was added 15 min before isometric tension measurements as a substrate.

Results: After final reperfusion, plasma XO activity had increased four-fold with a concomitant increase in superoxide production. The XO + NADH-dependent inhibition of vascular relaxation was reversible by addition of CuZn SOD.

Conclusion(s): Significantly more XO is released into the systemic circulation after intermittent PM, with subsequently increased superoxide production. The impaired nitric oxide bioavailability by the XO-induced superoxide after intermittent PM indicates hepatic surgery under PM might be beneficially managed using antioxidative drugs or anesthetics with a known antioxidative effect.

References:

A-666
Importance of nasopharyngeal sampling in the infection control of ICUs
A. Molnar, Z. Peto, E. Hajdu, R. Benko, A. Hortobagyi
Department of Anaesthesiology and Intensive Care, University of Szeged, Szeged, Hungary

Background and Goal of Study: ICU patients are at high risk to acquire nosocomial infections, which could greatly influence the clinical outcome. Hence the early detection of these infections and the adequate antimicrobial treatment are essential. We aimed to screen nasal colonisation and determine development rate of severe clinically and microbiologically proven infections (pneumonia, sepsis) caused by identical bacteria.

Materials and Methods: This retrospective study was performed for the 1999–2001 period at our 6-bed tertiary referral surgical ICU. All patients who were expected to stay over 48 hours at the ICU were routinely screened for nasal carriage of micro-organisms at admission and afterwards continuously (nasal swabbing on every 3rd day of stay). Positive endotracheal aspirates and positive blood cultures were retrieved for those patients who had proven nasal colonisation and were on antibiotic course due to clinically evident nosocomial infections.

Microbiologically positive endotracheal aspirates (EA) and blood cultures (BC) were analysed for the presence of identical bacteria previously found by nasal swabbing (NS).

Results and Discussions:

<table>
<thead>
<tr>
<th>Year</th>
<th>NOS</th>
<th>NS+</th>
<th>NS+ and EA+</th>
<th>NS+ and BC+</th>
<th>NS+ and EA+ and BC+</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>136</td>
<td>21</td>
<td>12</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>2002</td>
<td>133</td>
<td>55</td>
<td>23</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>2003</td>
<td>139</td>
<td>66</td>
<td>30</td>
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<td>4</td>
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</tbody>
</table>

NOS: Number of admitted patients with over 48 hour stay at ICU; -: positive culture.

Conclusion(s): Based on our results nearly 50 percent of patients with positive culturing of nasopharyngeal samples are expected to develop severe systemic nosocomial infections caused by identical pathogen and required antimicrobial treatment. Nasal swabbing can be of help in the early start of targeted antibiotic therapy and therefore can shorten the length of stay and lower healthcare expenses. Further studies are needed to determine the predictive value of nasopharyngeal sampling.

A-667
Surgical patients needing postoperative intensive care: a survey in Catalonia
Department of Anaesthesiology, Hospital Universitaris Germans Trias i Pujol, Badalona, Spain

Background and Goal of Study: Progress in surgery and anaesthesiology has gone parallel with the development of intensive and high dependency care units. Within an extensive survey of anaesthetic activity in Catalonia in 2003 (ANESCAT), we quantified and analysed characteristics of the patients requiring intensive postoperative care (IPOC).

Discussion: Generally the chemotherapeutic agents administered via the central vein catheter have thrombogenic effect. When we study our CVT diagnosed 5 patients we found out that all of them were over 50 years old, the mean catheter duration time was 6.8 days. But these results were not statistically significant when compared with the other patients under 50 years old and more than 8.8 days of mean catheter duration time. Out of 118 patients who were not under anticoagulation therapy 4 had CVT while 15 patients who had anticoagulant therapy 1 had CVT diagnose which was found statistically insignificant (p > 0.05).

Conclusion: We suggest that in order to get clinical significance of the causes that effect CVT, more sensitive investigations with higher number of patients must be studied.

A-668
Surgical patients needing postoperative intensive care: a survey in Catalonia
Department of Anaesthesiology, Hospital Universitaris Germans Trias i Pujol, Badalona, Spain

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NOS: Number of admitted patients with over 48 hour stay at ICU; -: positive culture.

Conclusion(s): Based on our results nearly 50 percent of patients with positive culturing of nasopharyngeal samples are expected to develop severe systemic nosocomial infections caused by identical pathogen and required antimicrobial treatment. Nasal swabbing can be of help in the early start of targeted antibiotic therapy and therefore can shorten the length of stay and lower healthcare expenses. Further studies are needed to determine the predictive value of nasopharyngeal sampling.
Materials and Methods: We designed a prospective and cross-sectional survey using information reported by anaesthesiologists through a questionnaire for every anaesthetic procedure performed during 14 randomised days along 2003. All public and private hospitals (131) practising anaesthesia around Catalonia (6,704,146 inhabitants) participated in the survey. The level of postoperative care required for every procedure was recorded. We calculated proportions of patients requiring IPOC and extrapolated to the entire activity and general population comparing patient characteristics.

Results and Discussions: A total of 23,136 questionnaires were collected. The proportion of patients needing IPOC was 7.7%, which extrapolates to 44,686 patients annually. The remaining only required recovery unit supervision. The median age (percentile 10-90%) of patients was 61 years (24-79). Distribution by gender was (54.8% male vs. 45.2% female). Those patients classified preoperatively as urgent (excluding obstetric cases) required IPOC more frequently (18.7% urgent vs. 7.9% elective). The percentage of ASA I, II, III and IV patients status classification requiring IPOC were (2.7%; 5.6%; 11.9%; 43.4%) respectively. The most frequent procedures performed were general surgery (25.1%), orthopaedics (25.0%) and cardiac surgery (10.8%). Surgical specialties with the highest proportion of patients requiring IPOC were cardiac (90.2%), thoracic (45.6%) and neurosurgery (44.3%).

Conclusion(s): About 0.66% of the Catalanian population has needed an intensive postoperative care unit during 2003. This figure is clearly higher to those observed in other national surveys (1). We foresee an increase in resources of IPOC due to increase in the number of oldest patients and more comorbidity among surgical population.

Reference:

A-668
Risk of pathogen growth in propofol administration systems
M.A. Staber, M. Whitelaw, F.J. de Villiers, J. Green, E.A.C. Biggs
Department of Anaesthesia, Inverclyde Royal Infirmary, Greenock, United Kingdom

Background and Goal of Study: Propofol is a short-acting intravenous anaesthetic agent, containing egg phosphatide, soya-bean oil and glycerol but no antimicrobial preservatives. Propofol has been implicated in hospital acquired infections and manufacturers insist on asepsis throughout the infusion period (1). Propofol infusions are often maintained for more than 24 hours, mainly in ICU at room temperature. We postulated that contamination of such infusion systems with pathogenic organisms could lead to sustained seeding of patients' bloodstream with increasing numbers of pathogens. This study was undertaken to establish (i) the ability of common pathogens to multiply in Propofol at room temperature, and (ii) the ability of pathogens to migrate upstream and multiply in the Propofol reservoir.

Materials and Methods: Four common local pathogens (MRSA, P aeruginosa, P mirabilis and C albicans) were inoculated separately into Propofol, incubated at 35°C and periodically subcultured. Subsequently, administration setups were contaminated at probable entry sites (mechanical junctions) with an equal mixture of the four pathogens. Systems were maintained at room temperature, sampled at 2 and 18 hours, sub-cultured onto blood (Oxoid) and cled (Oxoid) agar, and incubated in air at 35°C. Inoculum weights of 100 cfu/ml were used throughout, equaling the maximum total organism load on hands of Healthcare Workers (HCW) in our hospital. Appropriate controls were performed throughout.

Results and Discussions: Maximum inoculum weight from HCW hands in our hospital was 100 cfu. At 35°C MRSA, P aeruginosa, P mirabilis and C albicans grew exponentially in propofol. No growth or upstream migration occurred at room temperature over 24-hours.

Conclusion(s): At 35°C propofol is an efficient growth medium for common pathogens, but at room temperature the pathogens MRSA, P aeruginosa, P mirabilis and C albicans were unable to multiply or migrate upstream in infusion systems. At low inoculum weight and room temperature, Propofol does not increase the risk of bloodstream contamination with exponentially multiplying pathogens.

Reference:

A-669
Haemodynamic monitoring during lung recruitment: ScvO2 or CO2?
A. Mikor, I. Toth, T. Leiner, T. Szakmany, Z. Molnar
Department of Anaesthesia and Intensive Therapy, University of Pecs, Pecs, Hungary

Background and Goal of Study: High intrathoracic pressures during lung recruitment may cause haemodynamic instability (1). The question in this study was whether central venous oxygen saturation (ScvO2), CVP or MAP monitoring could replace cardiac output (CI) measurements during lung recruitment.

Materials and Methods: 10 patients suffering from ARDS were recruited. All patients were ventilated in pressure control mode (FiO2 = 1.0, respiratory rate = 20, I:E = 1:1). Following basic haemodynamic measurements and blood gas analysis alveolar recruitment was done: PEEP was set at 26 of cmH2O then 40 cmH2O of pressure amplitude was applied for 40 seconds. Optimal PEEP was then determined as follows: Vt was reduced to 4 ml/kg, then the PEEP was reduced from 26 by 2 cmH2O in every 4 minutes and the optimal PEEP was defined as 2 cmH2O above the level of PEEP where the PaO2 suddenly dropped by >10%. After setting the PEEP at the optimal level, the “40-40” manoeuver was applied again and the tidal volume was set as 6ml/kg. Haemodynamic parameters determined by arterial thermol dilution (PiCCO) and ScvO2 were measured during lung recruitment, then in every 8 minutes till the optimal PEEP was reached. For statistical analysis Pearson’s correlation was performed.

Results and Discussions: There was a significant positive correlation between CI and ScvO2 (r = 0.432, p < 0.002), significant negative correlation between CI and CVP (r = -0.402, p = 0.003) and no correlation was found between CI and MAP (r = -0.180, p = 0.89).

Conclusion(s): The results of this pilot study suggest, that ScvO2 monitoring may be an alternative to invasive haemodynamic monitoring during lung recruitment or when defining optimal PEEP in ARDS.

Reference:

A-707
Hyperthermia at intensive care of tickborne meningoen cephalitis severe courses
A. Lopatin, S. Antonov, A. Phillippov, V. Chigray
Department of Anaesthesiology, Hospital, Khabarovsky, Russia

Tickborne virus meningoencephalitis (TBM) is an infectious disease widely spread on territory of Russia, some Asian and European countries. With its severe courses like meningoencephalitis, poliomylitis, poliencephalitis and poliencephalomielitis lethality up to present time reaches 70–90%. Before 1970th patients mostly died from severe courses of meningoencephalitis in acute period of the disease but in the period of 1999 and 2000 there were observed no cases of lethality from meningoencephalitis itself but it was caused by its complications.

Goal: To define significance of hyperthermia in intensive therapy at severe cases of Tickborne meningoencephalitis.

Materials and Methods: Analyses of 38 records of treatment patients with severe cases of Tickborne encephalitis were performed. All patients showed brain edema, body temperature 38–39°C, impairment consciousness level up to 11–12 score at Glasgo scale, bulbar disturbances up to 12–13 score at Pittsburg scale. All patients were artificially lung ventilates (ALV) from the first day their staying at the hospital. There were defined two groups of patients. The first group (control) of 18 patients received traditional treatment according to a record not including hyperthermia and the second group (experimental) of 20 patients together with traditional therapy undergone hyperthermia. Hyperthermia was conducted from the first hours of patient’s admittance to the intensive care unit. Hyperthermia was reached by lowering body temperature to 32–34°C covering head with ice. Hyperthermia was applied within two or three days and then evaluation of neurological status was made. If brain edema clinics remain hyperthermia was continued up to five days. ALV continued till full spontaneous breathing restored.

Results: Lethality in control group made 65% in experimental group it made 35%.

Period of coma with the patients of the first group was within 10–15 days and in the second group it made 4–6 days.

Conclusions: Hyperthermia is an effective method in complex therapy of acute faze of meningoencephalitis.
out to clarify whether the relationship of VO2I and the depth of sedation could be influenced by the degree of surgical invasion.

**Materials and Methods:** We studied 30 patients undergoing either major abdominal surgery (group A; n = 24) or anterior-posterior cervical spine surgery (group B; n = 6), who required mechanical ventilation overnight postoperatively. VO2I was measured with Puritan-Bennett 7250 Metabolic Monitor. In addition to VO2I measurements, Ramsay sedation scale (RSS) was evaluated by the nursing staff. The measurement was done after the patients rested for at least 30 minutes. The measurements were made every 2 hours, and a total of 168 measurements was performed. Midazolam was used for induction and maintenance of intravenous sedation after admission to the ICU. The initial dose was 0.04 mg/kg/hr and the dose was adjusted by varying the dose by 10% increase or decrease to maintain the adequate depth of sedation (RSS 3–5). The depth of sedation was classified into 3 states, ie, light sedation (RSS 2–3), moderate sedation (RSS 4) and heavy sedation (RSS 5–6). CRP was evaluated as deltaCRP, the difference between the preoperative values and the values 2 days after operation.

**Results and Discussions:** Data are presented mean plus minus SD, deltaCRP of group A was significantly higher than that of group B (15.7 plus minus 8.2 mg/dl and 7.1 plus minus 4.3 mg/dl, respectively). The heavy sedation state showed a significantly lower value of VO2I compared with the moderate and light sedation states in group B. In contrast, there was no correlation between VO2I and RSS in group A.

**Conclusion(s):** The results of deltaCRP show that group A had a greater degree of inflammation than group B. The results suggest that the inflammatory state could modify the relationship between sedation and oxygen consumption.

**References:**

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**A-675**

**Family needs in the Intensive Care Unit: development of a questionnaire**

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Department of Intensive Care Medicine, Klinik für Innensmedizin, Bern, Switzerland

**Background and Goal of Study:** Survival and quality of life are the primary aims in medicine. Another important aspect is satisfaction of needs of patients and next of kin. Validated instruments for assessment of family needs and satisfaction have been developed for North America. No instrument exists in Europe, except for France. This study assesses content validity of such a questionnaire.

**Materials and Methods:** A German version of a validated questionnaire was created. The translated instrument was presented to patients, next of kin, ICU nurses and ICU physicians to assess content validity including the following: understandability of each of the 42 items of the questionnaire, relevance of each item, appropriateness of wording, length, completeness of the questionnaire, range of answers and overall impression.

**Results and Discussions:** 39 questionnaires with sufficient answers were returned.

**Overall impression:**
- Excellent or very good: 71.8%
- Satisfactory: 10.3%
- Unsatisfactory or poor: 5.1%
- Empty: 12.8%

**Coverage:**
- Absolutely or mostly complete: 82.0%
- Reasonably complete: 2.6%
- Unsatisfactory or poor: 0.0%
- Empty: 15.4%

**Overall understandability:**
- 90.0%
- Overall relevance to Swiss culture: 85.5%

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**A-676**

**The role of probiotics in preventing multiple-trauma patients from infections in Intensive Care Unit (I.C.U)**


1st I.C.U., KAT Hospital Greece, Kifissia, Greece

**Background and Goals:** Infections, in I.C.U. multiple-trauma patients (head trauma, thoracic trauma, surgical trauma, fractures), is a big nightmare for I.C.U. doctors. The administration of antibiotics in preventing such infections has caused many discussions. Is the PROBIOTICS administration, a way.

**References:**

**Acknowledgement:** supported in part by Astra Zeneca.

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**A-674**

**Could we rely on a new portable echocardiograph to assess bedside haemodynamics in the critically ill?**

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Department of Cardiac Anaesthesia & Postoperative Cardiac Surgical, University Hospital, Gent, Gent, Belgium

**Background and Goals:** The classic echocardiographic machine is large and bulky. Till now, visualisation with portable echocardiographs was limited. We aimed to evaluate for the first time in Europe an echocardiograph in notebook format for clinical use in an ICU.

**Material and Methods:** A Vivid 7 echocardiograph (GE Ultrasound, Horton, Norway) was compared with a new handheld device, Vivid 7 (GE Ultrasound, Haifa, Israel). We studied 25 cardiac surgical patients. All patients underwent two consecutive transthoracic echocardiographic examinations, performed by two independent anaesthetists, well trained in echocardiography. After measuring left ventricular end-systolic and diastolic area, mean aortic valve area (AVA) and time velocity integral of the flow across the aortic valve (TVI), we calculated: stroke volume (SV), cardiac output and fractional area contraction (FAC). Agreement between the haemodynamic measurements was assessed with ANOVA multi-variance analysis and a Bland and Altman analysis.

**Results and Discussion:** The intraobserver and interobserver variability for both hemodynamic measurements were respectively 3–7% and 4–7%.
performed everyday, in both groups. Symptoms like vomiting and diarrhoea were being monitored.

**Results:** The administration of Saccharomyces bulardii (caps ultra-levure) was well accepted, without side effects. During the first 10 days from the day of entrance in I.C.U., in group A two (2) cases of certified infection have been noted, whereas in group B seven (7) cases of certified infection have been noted. The difference between the two groups is statistically significant (p = 0.04).

**Conclusions:** The administration of Saccharomyces bulardii as prophylaxis to I.C.U. patients, reduces the danger of a future infection to them. Saccharomyces bulardii (caps ultra-levure) is well accepted by the patients and the cost of treatment is very low.

References:

A-677
Voltage-gated sodium channel changes in NMJ during sepsis
B. Rossignol, G. Kiss, G. Gueret, C.C.A. Arvieux
Department of Anesthesiology, Hospital, BREST, France

**Background and Goal of Study:** Sepsis is one of multiple factors responsible for polyneuropathy in the ICU. Voltage-gated sodium channels (Na(v)1s) in neuromuscular junctions (NMJ) play a role in the propagation of the action potential. The objective of our work is to study the impact of sepsis on the functionality of Na(v)1s.

**Materials and Methods:** The study was realised on two groups of rats: group S rats underwent caecal ligation and puncture and C rats were the control group. Using the patch-clamp technique in isolated rat flexor digitorum brevis myofibers, we investigated the electrophysiological effects on Na(v)1s 10 days after the start of sepsis.

**Results and Discussions:** 63 and 36 measurements were realised in group S and C respectively. Voltage dependence of peak Na+ conductance (gNa) was low 10 days after the start of sepsis. We conclude that it is possible to calculate from conductance the number of open gate channels in Na(v)1s 10 days after the start of sepsis.

**Conclusions:** These results show that sepsis induces modification of the electrophysiology of Na(v)1s at NMJ. This can be due to modification of the number of channels, or variation of their subunits. Further studies must be done to confirm this hypothesis.

A-687
Euglycemic hyperinsulinemia in a ewe septic shock model
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Intensive Care Dept, Erasme University Hospital, Brussels, Belgium

**Introduction:** Euglycemic hyperinsulinemia (EH) has been shown to reduce plasma concentrations of tumour necrosis factor alpha in lipopolysaccharide-induced systemic inflammation in pigs (1). The aim of our study was to investigate whether EH could improve survival in a sheep septic shock model.

**Methods:** Fourteen anesthetized, mechanically ventilated, hemodynamically monitored sheep received 1.5-gm/kg body weight bacitracin intraperitoneally to induce sepsis. After two hours, animals were randomized to: EH group (n = 7) – insulin 0.25U/kg/hour, 20% glucose (to maintain blood glucose 40–90mg/dl), and potassium (to maintain potassium level 4.0–5.5mmol/L); control group (n = 7) – no insulin. Ringer’s lactate (RL) + hydroxyethyl starch (Voluven) (volume ratio = 1:1) was titrated to maintain pulmonary artery occlusion pressure (PAOC) at baseline level throughout the experimental period without administration of any antibiotics or vasoactive drugs. The animals were followed until spontaneous death or for a maximum of 30 hours.

**Results:** There were no differences between groups in blood glucose or potassium concentrations. Arterial insulin concentration was significantly higher in the EH group. Time to develop hypotension and oliguria was similar in both groups. PaO2/FiO2 decreased in both groups. Interleukin-6 (IL-6) levels initially increased in both groups but decreased more in the EH group than in the control group (p < 0.05). There was no difference in survival time (19.9 ± 2.2 vs 17.8 ± 2.7 hours, EH group vs control group respectively; p = 0.54).

**Conclusion:** In this clinically relevant septic shock model, EH seemed to have anti-inflammatory effects, reflected by lower IL-6 concentrations. However, EH did not have beneficial effects on hemodynamics, organ function, or survival.

Reference:

A-679
Can liver perfusion improve by adding dobutamine to norepinephrine in septic shock?
T. Leiner, I. Toth, A. Mikor, Z. Molnar
Department of Anesthesia and Intensive Therapy, University of Pecs, Pecs, Hungary

**Background and Goal of Study:** To investigate the effect of dobutamine when added to norepinephrine on liver perfusion as measured by the plasma disappearance rate (PDR) of indocyanine green (ICG) in septic shock.

**Materials and Methods:** 10 patients fulfilling the criteria of septic shock were recruited in this auto-control clinical trial. Mean arterial pressure (MAP) was kept above 70mmHg with norepinephrine and invasive haemodynamic monitoring by PICCO was commenced. Hypovolaemia as indicated by intrathoracic blood volume index (ITBVI) <850 ml/m², was corrected and then the ICG PDR was measured by the LI-MON, by giving 0.25 mg/kg ICG. If PDR <18% dobutamine was administered at a rate of 5 μg/kg/min. After 60 minutes of treatment haemodynamic and PDR measurements were repeated. Blood samples were taken when haemodynamic stability by norepinephrine was achieved (t₀) and after one hour of inotropic support (t₁). Serum lactate, CRP, PCT levels, liver and renal function and blood gas analysis (arterial and central venous) were performed. For statistical analysis paired sample T-test was used.

**Results and Discussions:** There was no difference in cardiac output (4.0 ± 0.9 vs. 4.0 ± 0.9 L/min/m², p = 0.91), heart rate (102 ± 5 vs. 108 ± 25/min, p = 0.99), central venous haemoglobin saturation (76 ± 9 vs. 77 ± 10%, p = 0.37), and serum lactate levels (1.75 ± 1.45 vs. 2.15 ± 1.40 mmol/L, p = 0.36) between the two measurement points. PDR increased slightly but it did not achieve statistical significance (14.7 ± 6.7 vs. 16.1 ± 8.7%, p = 0.22).

**Conclusion(s):** The results of this pilot study suggest that routine administration of dobutamine to norepinephrine in order to improve liver perfusion in septic shock cannot be supported, as indicated by the non-significant change in ICG PDR. These results are in contrast to recent animal data (1), however, the completion of the study is required to come to firm conclusions.

Reference:

A-681
Terlipressin or norepinephrine in hyperdynamic septic shock: a prospective, randomized study
J. Albanèsè, M. Leone, A. Delmas, F. Garnier, C. Martin
Anesthèse et Réanimation, CHU Nord, Marseille, France

**Background and Goals:** To compare, in patients with hyperdynamic septic shock, the effects of norepinephrine (NE) or terlipressin (TP) on haemodynamic parameters and renal function.

**Material and Method:** Twenty patients with hyperdynamic septic shock were prospectively randomized to receive NE or TP after fluid resuscitation. Global haemodynamic parameters, oxygen consumption, urine flow, creatinine clearance, and arterial blood lactate levels were measured.

**Results:** Mean arterial pressure, systemic vascular resistance, pulmonary vascular resistance, and left and right ventricular stroke work were significantly increased with both drugs. With TP, but not with NE, a significant decrease in heart rate (from 113 ± 17 to 104 ± 11b/min, p < 0.01) and cardiac index (from 5.1 ± 1.7 to 4.2 ± 1.6 L/min ·m², p < 0.05) was observed, with no change in stroke volume. Oxygen delivery (from 784 ± 131 to 701 ± 92 mL ·min⁻¹ ·m²) and consumption (from 244 ± 69 to 210 ± 54 mL ·min⁻¹ ·m²) were significantly decreased with TP, but not
A-682
Increasing mean arterial pressure in patients with septic shock: effects on oxygen variables and renal function
M. Leone, J. Albanèse, I. Boyadjev, F. Antonini, C. Martin
Anesthésie et Réanimation, CHU Nord, Marseille, France

Background and Goals: The effects of increasing mean arterial pressure (MAP) were measured on oxygen variables, and renal function in septic shock.

Material and Methods: Twenty-eight patients with septic shock who required fluid resuscitation and pressor agents to increase and maintain MAP > 60 mmHg were included in a prospective, open-label, randomized, controlled study. Patients were treated with fluid and norepinephrine to achieve and maintain a MAP of 65 mmHg. Then, they were randomized in two groups: in the first group (n = 14), MAP was maintained at 65 mmHg, and in the second group (n = 14), MAP was increased to 85 mmHg by increasing the dose of norepinephrine. Haemodynamic parameters (MAP, heart rate, mean pulmonary artery pressure, pulmonary artery occlusion pressure, cardiac index, systemic vascular resistance index, pulmonary vascular resistance index, left and right ventricular stroke index), metabolic parameters (oxygen delivery, oxygen consumption-calorimetric method, arterial lactate), and renal function parameters (urine flow, serum creatinine, creatinine clearance) were measured.

Results: After introduction of norepinephrine, similar values of haemodynamic, metabolic, and renal function parameters were obtained in both groups. No changes were observed in group 1 during the study period. Increasing MAP from 65 to 85 mmHg with norepinephrine in group 2 resulted in a significant increase in cardiac index from 4.8 ± 1.8 to 6.0 ± 1.6 L min⁻¹ m⁻² (P < 0.01). Arterial lactate (3.1 ± 1.4 and 2.6 ± 1.6 mmol L⁻¹) and oxygen consumption (247 ± 32 and 228 ± 52 ml m⁻² min⁻¹ m⁻²) did not change. No changes were observed in renal function parameters: urine flow 61 ± 38 and 73 ± 46 ml, serum creatinine 163 ± 182 and 150 ± 143 µmol L⁻¹, and creatinine clearance 48 ± 39 and 70 ± 68 ml min⁻¹.1.73 m².

Conclusions: Increasing MAP from 65 to 85 mmHg with norepinephrine neither affects metabolic parameters nor improves renal function.

A-683
A possible role of white adipose tissue in sepsis
Department of Anaesthesia, The University of Liverpool, Liverpool, United Kingdom

Background and Goal of Study: It has recently been established that white adipose tissue, besides its metabolic role, storing and releasing fatty acids, has a major role in secreting a variety of hormones and mediators which are referred to as adipokines.  

In particular, it has been suggested that adipose tissue releases pro-inflammatory cytokines, e.g. IL-6 in response to hypoxia. Thus we felt tempted to investigate how adipokine expression relates to sepsis in an animal model.

Methods: After obtaining a Home Office licence under the Animal Rights Act, we investigated sixteen healthy, non-obese male mice (body weight 25–28 g). Eight animals served as controls, in another eight animals, sepsis was induced by intra-peritoneal LPS injection. Twenty-four hours after induction of sepsis, the experimental animals were killed and RNA extracted from epididymal fat was investigated by real time PCR, in order to quantify expression of IL-6, IL-18, nerve growth factor (NGF), hypoxia-induced factor (HIF), adipin and adiponectin in comparison to controls.

Results: Twenty-four hours after induction of sepsis, real time PCR revealed significant increases in the expression of IL-6 (500 fold), NGF (10 fold), TNFα (5 fold) and HIF (3 fold), while there were significant decreases in the expression of IL-18 (0.4 fold), adipin (0.15 fold) and adiponectin (0.2 fold).

Conclusions: These results show that white adipose tissue is an organ system which actually suffers from hypoxia during sepsis. It responds by a marked increase in the expression of pro-inflammatory cytokines. At the same time, the expression of anti-inflammatory cytokines as well as the expression of adipin and adiponectin is reduced. Thus, we propose the hypothesis that white adipose tissue may be an important contributor to the pathophysiology of sepsis.

Materials and Methods: After institutional approval, a median thoracotomy was performed in 32 pigs and they were instrumented for measurement of CI and mean arterial pressure (MAP). After induction of a 4 minute period of ventricular fibrillation, the circumflex coronary artery was ligated. All pigs received a standard open heart CPR according to the ILCOR 2000 guidelines. The pigs were randomised into four different vasopressor groups (each n = 8). G1 (EPI 30 µg/kg); G2 (VP 0.4 IU/kg); G3 (VP 0.2 IU/kg) + EPI 15 µg/kg); G4 (VP 0.4 IU/kg + MIL 50 µg/kg bolus over 5 min. and 0.4 µg/kg/min). CI and MAP were measured before CPR and 4.8,15 and 30 min after restoration of a spontaneous circulation (ROSC). ANOVA for repeated measures was used, p < 0.05 was considered statistically significant, all data are expressed as mean ± SD.

Results and Discussions: All animals were resuscitated successfully and showed no significant differences in MAP.

### Cardiac index (CI ml/min/kg)

<table>
<thead>
<tr>
<th></th>
<th>G1</th>
<th>G2</th>
<th>G3</th>
<th>G4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before CPR</td>
<td>118 ± 24</td>
<td>139 ± 38</td>
<td>109 ± 24</td>
<td>146 ± 38</td>
</tr>
<tr>
<td>ROSC + 4</td>
<td>113 ± 38b</td>
<td>102 ± 41b</td>
<td>114 ± 15b</td>
<td>169 ± 64</td>
</tr>
<tr>
<td>ROSC + 8</td>
<td>106 ± 42</td>
<td>76 ± 27b</td>
<td>117 ± 39</td>
<td>128 ± 41</td>
</tr>
<tr>
<td>ROSC + 15</td>
<td>67 ± 24b</td>
<td>70 ± 19b</td>
<td>88 ± 39</td>
<td>121 ± 23</td>
</tr>
<tr>
<td>ROSC + 30</td>
<td>66 ± 13b</td>
<td>71 ± 16b</td>
<td>69 ± 36b</td>
<td>121 ± 35</td>
</tr>
</tbody>
</table>

*p < 0.05 compared to G4.

Conclusion(s): VP + MIL compared to all other groups improves significantly CI without a decrease in MAP. It therefore could be an alternative to ADR for CPR and should be further investigated.

References:

### A-687
Impairment of correct ECG-analysis of automated external defibrillators due to electromagnetic interference

B. Roessler, R. Fleischhackl, F. Singer, W. Nitsche, K. Hoerauf
Research Department, Research Institute Vienna Red Cross, Vienna, Austria

**Background and Goal of Study:** Automated External Defibrillators (AEDs) have been designed to provide lifesaving shocks within the first, decisive minutes after sudden cardiac arrest. As ECGs are obtained from the body surface, electromagnetic fields were detected to weaken signal quality [1].

We tested the hypothesis that strong electromagnetic fields are not able to impair correct ECG-analysis and produce wrong positive shocks in AEDs currently available in Austria.

**Materials and Methods:** Five AEDs were tested: Access® (Access CardioSystems), CR+® (Medtronic), Fred Easy® (Schiller), HS1® (Philips), Responder® (GE Healthcare). Four sites were selected in a transformer substation, which provided strongest electromagnetic fields generated by high voltage power lines (50Hz ac) and power lines for the Austrian Railway Company-network (1650 Hz dc). Participants were laid on the floor and tested parallel and perpendicular to the source.

**Results and Discussions:** The AEDs were tested on 19 healthy subjects at 4 sites (n = 152 for each AED).

<table>
<thead>
<tr>
<th>AED</th>
<th>Wrong Pos. (n/%)</th>
<th>True Neg. (n/%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access®</td>
<td>0/0</td>
<td>152/100%</td>
</tr>
<tr>
<td>CR+®</td>
<td>0/0</td>
<td>152/100%</td>
</tr>
<tr>
<td>Fred Easy®</td>
<td>4/2.63%</td>
<td>148/97.37%</td>
</tr>
<tr>
<td>HS1®</td>
<td>0/0</td>
<td>152/100%</td>
</tr>
<tr>
<td>Responder®</td>
<td>9/5.92%</td>
<td>143/94.08%</td>
</tr>
</tbody>
</table>

Our findings suggest that strong electromagnetic fields are able to impair ECG-analysis of AEDs. Since wrong positive results did not occur in all devices tested, we conclude that models of different manufacturers are equally susceptible to electromagnetic interference. As the areas studied were of restricted access, further research will be necessary to evaluate the impact of electromagnetic interferences on AED analysis in places accessible to the general public.

**Conclusion:** Some of the AEDs available in Austria are susceptible to strong electromagnetic fields.

Reference:

### A-688
Peripheral cardiac arrest and cardiopulmonary resuscitation: are we doing it right? experience from a developing country

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Department of Anaesthesia, College of Medicine, University of Lagos, Nigeria

**Background and Goal of Study:** Cardio-pulmonary resuscitation is an integral part of anaesthetic training. In Nigeria, these skills are taught mainly during medical school and postgraduate training. The study sought to assess how closely anaesthetists in a Nigerian teaching hospital abide by existing guidelines?

**Materials and Methods:** All perioperative adult cardiac arrest that occurred in 2003 were prospectively studied. All patients <12 years and cardiac arrests occurring outside the direct supervision of the anaesthetists were excluded. Duration of arrest, cardiac arrest rhythm, management and care of presiding anaesthetist were documented along with immediate outcome.

**Results and Discussions:** Thirteen cardiac arrests occurred in 2147 cases resulting in an incidence of 6 per 1000. The mean age of patients was 30.23 ± 11.06 years. Orotracheal intubation, manual ventilation with 100% O2 and cardiac compressions were instituted in all cases. Seven patients had non-VF/VT rhythms.

<table>
<thead>
<tr>
<th>Therapy given</th>
<th>Number of patients</th>
<th>Mean dose (SD)</th>
<th>Mean number of doses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epinephrine</td>
<td>13</td>
<td>2.9 mg (1.3)</td>
<td>3.6</td>
</tr>
<tr>
<td>Atropine</td>
<td>13</td>
<td>2.7 mg (1.8)</td>
<td>1.6</td>
</tr>
<tr>
<td>Defibrillation</td>
<td>3</td>
<td>880 J (207)</td>
<td>3</td>
</tr>
</tbody>
</table>

The mean duration of arrest was 25.7 ± 13.3 minutes. The average interval between epinephrine doses was 7.5 minutes which is more than twice the recommended guidelines. Atropine was administered
regardless of cardiac arrest rhythm and defibrillation was not optimal. Immediate survival occurred in 5 patients (38.46%).

**Conclusion(s):** Anaesthetists in our hospital are not applying proper resuscitation guidelines. The lack of organized simulation practice resulted in deficient knowledge and skills. There is a need for a dedicated cardiac arrest team to ensure frequent practice in cardiopulmonary resuscitation.

**A-689**

**Advanced life support and critical care in spaceflight**


Department of Life Sciences, International Space University, Strasbourg, France

**Background and Goal of Study:** Increased human presence in space within the next decades requires clear guidelines for treatment of medical emergencies onboard manned orbital platforms.

**Materials and Methods:** During an international TEMOS project, sponsored by German Aerospace Agency DLR, scenarios for the most likely medical emergencies with high impact on mission outcome were investigated.

Trauma with burns and inhalation injury, severe cardiac dysrhythmias with myocardial ischemia, internal haemorrhage with hypovolemic shock and complex situations during extravehicular activities with loss of space suit integrity. Procedures and devices were tested in Gagarin Cosmonaut Training Centre Russia in spacecraft mock-ups, in centrifuges and in parabolic flights. Algorithms were developed and tested in Human Patient Simulator in Germany. Broadband tele-medical links were utilized when applicable.

**Results and Discussions:** Proposed changes include: modification, standardisation and addition of telemedicine equipment in space segment and in ground facilities, improvement of ALS algorithms on board the ISS and Soyuz TM spacecraft, addition of drugs, instrumentation, diagnostic devices and ALS-related hardware to the existing ISS medical equipment, upgrade of Soyuz TM descent vehicle for ALS during de-orbit, modification of re-entry trajectories, implementation of standard protocol for vital data collection using minimal intrusive monitoring devices and the use of HPS as an additional tool for decision making support in operational space medicine.

**Reference:**

1 TEMOS Project, German Aerospace Agency 2001-2004.

**A-690**

**Volume expansion to increase preload during cardiopulmonary resuscitation (CPR) with continuous airway pressure (CPAP)**

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Department of Anesthesiology, Johannes-Gutenberg-University, Mainz, Germany

**Background and Goals:** This investigation was designed to evaluate the changes in haemodynamics and blood gases under repetitive volume expansion during CPR with a continuous airway pressure (CPAP). The aim was to evaluate the amount of volume needed to see significant changes in these parameters.

**Material and Methods:** Nine domestic swine (weight: 25 kg) were studied after induction of ventricular fibrillation. After two minutes external chest compression were initiated at a rate of 100 cpm (Thumper) combined with a CPAP of 30 mmHg. Also intravenous epinephrine administration, as a bolus (45 µg/kg), followed by a continuous infusion (13 µg/kg per min). Three minutes later the first of five volume applications (Voluven 200 ml each) was given. Before and after each application, arterial blood gases, acid base status, haemodynamics (MAP, CO, CPP, CoPP) and tidal volumes were sampled.

**Results:** The CPR-protocol was performed in nine piglets. The mean arterial blood pressure (MAP) decreased during CPR with a continuous airway pressure (CPAP). The mean intervention time was 11 min and 3 sec. Five min after intervention, both MAP (60 ± 12 mmHg) and CPP (32 ± 11 mmHg) decreased significantly (Baseline vs. intervention: VP: 84 ± 17 vs. 19 ± 5 mmHg; RR: 76 ± 2 vs. 27 ± 1 mmHg; P < 0.05), and heart rate (HR) increased significantly (Baseline vs. intervention: VP: 88 ± 8 vs. 201 ± 33 bpm; RR: 104 ± 6 vs. 206 ± 6 bpm; P < 0.05) with haemorrhage in all animals. A significant drop of MAP values was observed before haemodynamic decomposition (Baseline vs. intervention: VP: 64 ± 3 vs. 48 ± 12; RR: 59 ± 3 ± 48 ± 5; P < 0.05), although MAP and HR were still above the defined intervention threshold. Mean intervention time was VP: 32 ± 6 vs. RR: 37 ± 4 min. Following 5min after intervention, both MAP (60 ± 12 mmHg) and CPP (32 ± 11 mmHg) decreased significantly (Baseline vs. intervention: VP: 84 ± 17 vs. 19 ± 5 mmHg; RR: 76 ± 2 vs. 27 ± 1 mmHg; P < 0.05), and heart rate (HR) increased significantly (Baseline vs. intervention: VP: 88 ± 8 vs. 201 ± 33 bpm; RR: 104 ± 6 vs. 206 ± 6 bpm; P < 0.05).

**Conclusion(s):** Avoiding the negative influence of CPAP on venous return by increasing preload might be a mechanism explaining these results.

**A-691**

**Combination of hypertonic saline and vaptressin in CPR of domestic pigs**

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Anesthesiologie und Intensive Care Medicine, University of Bonn, Bonn, Germany

**Background and Goal of Study:** Several studies showed that application of vasopressin (1) and hypertonic saline (2,3) during CPR improves resuscitation success. Though the combination of these promising medications has not been tested yet.

**Materials and Methods:** Cardiac fibrillation was induced in 40 domestic pigs. After 6 minutes of cardiac arrest CPR was started. Animals were divided in four groups. They received either epinephrine and normal saline (Gp I) or epinephrine and hypertonic saline (NaCl 7.2%, Gp II) or vasopressin and normal saline (Gp III) or vasopressin and hypertonic saline (IV). After 5 minutes of cardiac arrest animals were defibrillated. Arterial, left ventricular, central venous and intracranial pressures were measured continuously. Myocardial (MPP) and cerebral perfusion pressures (CPP) were calculated. Myocardial (MBP) and cerebral blood flows (CBF) were measured by coloured microspheres before cardiac arrest and during CPR.

**Results and Discussions:**

Resuscitation success was significantly higher in group II than group I and significantly higher in group IV than in I and III (p < 0.05). CBF and MBF in group II and IV were significantly higher than in I and III (ANOVA, p < 0.05) and CPP did not differ.

**Conclusion(s):** Application of hypertonic saline effects higher resuscitation success by increasing myocardial and cerebral blood flow in combination with vasopressin as well as in combination with epinephrine. Vasopressin is not superior to epinephrine.

**References:**


**A-692**

**Bipspectral Index (BIS) is improved after vasopressin, but not after fluid resuscitation therapy during uncontrolled haemorrhagic shock**

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Department of Anaesthesiology and Intensive Care Medicine, University Hospital Schleswig-Holstein, Campus Kiel, Kiel, Germany

**Background and Goal of Study:** Recent investigations reported a correlation between the bispectral index (BIS) and cerebral hypoperfusion during CPR. Avoiding the negative influence of CPAP on venous return by increasing preload might be a mechanism explaining these results.

**Results and Discussions:** Mean arterial blood pressure (MAP) decreased significantly (Baseline vs. intervention: VP: 84 ± 17 vs. 19 ± 5 mmHg; FR: 76 ± 2 vs. 27 ± 1 mmHg; P < 0.05), and heart rate (HR) increased significantly (Baseline vs. intervention: VP: 88 ± 8 vs. 201 ± 33 bpm; RR: 104 ± 6 vs. 206 ± 6 bpm; P < 0.05) with haemorrhage in all animals. A significant drop of BIS values was observed before haemodynamic decomposition (Baseline vs. intervention: VP: 64 ± 3 vs. 48 ± 12; RR: 59 ± 3 ± 48 ± 5; P < 0.05), although MAP and HR were still above the defined intervention threshold. Mean intervention time was VP: 32 ± 6 vs. RR: 37 ± 4 min. Following 5min after intervention, both BIS (69 ± 18) and MAP (58 ± 21 mmHg) had increased in the VP group, while BIS (77 ± 7) and MAP (30 ± 3 mmHg) could not be stabilised in the FR group.
Conclusion(s): In this porcine model of uncontrolled haemorrhagic shock, BIS indicated an impaired cerebral circulation and beginning haemodynamic decompensation. Administration of vasopressin, but not fluid resuscitation therapy, stabilised MAP and BIS.

References:

A-693
Brain metabolism assessed with microdialysis during fluid resuscitation in uncontrolled haemorrhagic shock after penetrating liver trauma
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Background and Goal of Study: Intracerebral microdialysis is a sensitive tool to analyse metabolic changes (1). Lactate (La) and the lactate/pyruvate (La/Py) ratio are important markers of the redox state of tissue, while elevated glycerol (Gly) indicates cell membrane damage (2). The purpose of this study was to investigate brain metabolism during fluid resuscitation in an established porcine model of uncontrolled haemorrhagic shock.

Materials and Methods: Following approval of the Animal Investigation Committee, 9 healthy piglets (12 to 16 weeks, 38 to 42 kg) underwent general anaesthesia. After preparing a small burr hole, a microdialysis catheter was inserted into the cerebral cortex. An incision across the right liver lobe was performed to simulate a penetrating liver trauma. When mean arterial pressure was less than 25 mm Hg, or heart rate declined progressively to less than 20% of its peak value, all animals were treated with a combination of Ringer’s solution (R; 40 ml kg⁻¹) and hydroxyethyl starch (HES; 20 ml kg⁻¹) over 30 minutes. FiO₂ was raised to 100%. After fluid administration, bleeding was controlled by manual compression of the liver. All surviving animals were observed for one hour, while ventilated with a FiO₂ of 50%.

Results and Discussions: Six out of nine animals survived up to the final measurement. At the point of haemodynamic decompensation cerebral interstitial La, La/Py ratio and Gly increased compared to baseline (BL) (mean ± SEM; La 2.1 ± 0.6 mM L⁻¹ vs. 0.9 ± 0.1 mM L⁻¹; P < 0.05; La/Py ratio 0.03 ± 0.01 vs. 0.01 ± 0.01; P < 0.05; Gly 30.1 ± 6.0 μM L⁻¹ vs. 17.0 ± 2.5 μM L⁻¹; P < 0.05), respectively. After fluid resuscitation, La and La/Py ratio decreased again, while Gly further increased (42.9 ± 8.7 μM L⁻¹ after 60 min vs. BL; P < 0.05).

Conclusion: In this model of uncontrolled haemorrhagic shock, changes of cerebral energy metabolism detected by intracerebral microdialysis indicated anaerobic glycolysis and degradation of cellular membranes during haemodynamic decompensation.

Reference:

A-694
A search for safe and rapid method of immobilization. A study in macaque monkeys
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Background and Goal of Study: After the rapid incapacitation of persons in Moscow theatre ended in disaster of 119 dead people, it is probably wise to educate and involve anaesthesiologists in the search of rapid and safe forms of immobilization suitable for disaster medicine. Till now some research is published about the use of benzodiazepines, opioids and α₂ antagonists for induction of totally reversible immobilization in small laboratory animals. If such a combination is suitable for immobilization in man, it should be tested in Macaque monkey first, because of its similarity to man concerning the sensitivity to respiratory depression.

Materials and Methods: After Ethical Committee approval ten laboratory Macaque Mulatta monkeys, weight 3.2 ± 0.5 kg, were given an injection containing the combination of midazolam (0.25 mg kg⁻¹), medetomidine (50 μg kg⁻¹) and fentanyl (5 μg kg⁻¹) into the deltoid muscle. Onset time (beginning of ataxia), immobilization time (the moment of sinking to the floor) and loss of grip reflex time were obtained. After immobilization haemoglobin saturation and pulse rate were recorded. 20 minutes after the first injection atipamezol (250 μg kg⁻¹ IM), a specific α₂ antagonist, was given and recovery time recorded. Paired t-test with Bonferroni correction was used to analyze the changes in pulse rate.

Results and Discussions: Data are presented as means ± SD. Onset time was 85.8 ± 14.6 s, immobilization time 221 ± 44.6 s, loss of grip reflex time 235.7 ± 43.2 s. Haemoglobin saturation remained above 90% in all the cases. Pulse rate did not change significantly (P = 0.78), Recovery time was 252 ± 96 s after atipamezol injection. Immobilization was induced in all the monkeys. There was no severe respiratory depression or cardiovascular instability during the study period. Short recovery time after antagonization shows prevailing α₂ agonist component.

Conclusion(s): The present method of totally reversible immobilization is reliable, rapid and safe method in Macaque monkey. Our results encourage similar studies in healthy volunteers.

A-698
Safe use of the Cobra-PLA device in anaesthesia and in an emergency
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Background and Goal of Study: The face mask, laryngeal mask, and the Combitube are devices commonly used to ventilate the lungs of nonintubated patients, but some disadvantages may result in inadvertent ventilation-associated complications. The Cobra-PLA is a new alternative in managing the airway (1).

Materials and Methods: The aim of this study was to assess whether the newly developed Cobra-PLA can provide sufficient ventilation and adequate oxygenation in patients with predictable difficult airway undergoing routine induction of anaesthesia and in an emergency.

Results and Discussions: We studied 16 patients, ASA physical status I–IV, and were allocated in 2 groups of 8 patients each: Control Group (CR) patients underwent general anaesthesia for non-cardiac surgery with predictable difficult airway (Mallampati score 3–4, limited cervical mobility, interincisal dental distance <5 cm) and Emergency Group (E) of patients with unpredictable difficult airway underwent general anaesthesia for emergency surgery. In all cases, the Cobra-PLA was inserted successfully on the first attempt (range, 8 to 29 s; median, 21 s). Ventilation and blood gas variables 10 min after the insertion revealed both sufficient ventilation and oxygenation in all patients. Insertion times for the Cobra-PLA were comparable to those reported for laryngeal mask airways.

Conclusion(s): The preliminary data suggest that the Cobra might be a simple, safe and effective alternative supraglottic device to the LMA Classic to secure the airway.

Reference:

A-699
Blind insertion of the EasyTube and detection of its position
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Background and Goal of Study: The EasyTube (EZT, Teleflex Rüsch, Kernen, Germany) is a new tube with two lumina for managing anticipated as well as unanticipated airway difficulties. The device is designed to provide sufficient ventilation whether its tip is positioned into the oesophagus or into the trachea. This study was initiated to evaluate the position of the EZT after blind insertion as well as two methods of detection.

Materials and Methods: After ethical committee approval and informed consent, the EZT was blindly inserted into 30 patients following standardized anaesthesia induction. The bulb-oesophageal detector device (EOD) as well as capnography (CAP) were used to detect the position of its distal end.

Results and Discussions: The tip of the EZT was positioned in the oesophagus in all patients. The EOD as well as CAP detected the supraglottic lumen to be used for ventilation correctly in all patients. The cross-check of the distal lumen positioned in the oesophagus revealed one ambiguous result out of 30 with the EOD.

Conclusion(s): Blind manual insertion causes a high probability of positioning the tip of the EZT into the oesophagus. The correct lumen to be used for ventilation can be detected successfully either by an EOD or by CAP.

References:

Acknowledgement: The EZT used in this study were provided by Teleflex Medical (Rüsch), Kernen, Germany.
A-700
Effect of increase in cardiac output on CO elimination under hyperoxic normoventilation
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Background: Many models, such as the CFK equation have considered CO uptake from the alveoli to the blood (1), however, there has not been any model capable of clearly explaining whether which CO elimination is perfusion-dependent or diffusion-dependent. The purpose of our study is to investigate whether CO elimination is perfusion dependent under normal ventilation with hyperoxic state.

Method: Five anesthetized dogs (18-26 kg) were exposed to 3000 ppm of CO in air until carboxyhemoglobin (COHb) levels reached 40 to 50%. Dogs were randomly assigned to one of two treatments. Hyperoxic normoventilation (HNV) for 60 min; or (2) HNV with dobutamin to increase cardiac output for 60 min. After completion of the treatment, the treatment was continued until COHb levels returned to control levels. Then the dog was re-exposed to CO and the other treatment applied. Control tidal volumes and respiratory rates for the two treatments did not differ. Arterial blood, sampled every five minutes, was analyzed photometrically for COHb. Cardiac output was measured by thermodilution every 5 min during treatment and used to calculate cardiac index (cardiac output/body surface area). The time constant of the fall in COHb (k) during each treatment was determined from a curve fit by method of least squares to values of log COHb plotted versus time. Values of halftime were calculated as (ln 2)/k. Data were expressed as mean ± SD.

Results: Cardiac indices were 4.2 ± 1.5 and 8.8 ± 3.0 L/min/m² in HNV and HNV with dobutamin treatments, respectively (p = 0.0032). The halftime of COHb elimination were 45.0 ± 9.0 and 50.8 ± 4.4 min in HNV treatments and HNV with dobutamin treatments, respectively, which were not significantly different between the two treatments.

Conclusions: Uptake of CO from alveoli to pulmonary capillary blood is stated to be diffusion dependent. Our study demonstrates that CO elimination from capillary blood to alveoli and pulmonary during HNV is also diffusion-dependent, but not perfusion-dependent. These findings suggest that an increase in cardiac output could not contribute to accelerating CO elimination during hyperoxic normoventilation.

Reference:

A-701
In-vivo test of bi-directional venturi pump for emergency transtracheal lung ventilation
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Background and Goal of Study: In case an emergency patient cannot be ventilated, however, passive expiration through a thin cannula can be attempted through a thin transtracheal cannula. If the upper airways are obstructed, however, passive expiration through a thin cannula may be inadequate, resulting in increased PEEP because of incomplete emptying of the lungs.

Materials and Methods: We adapted an ordinary “venturi pump” to provide active deflation of the lungs. High oxygen flow through the narrow outlet produces negative gas pressure in the side tube (“expiration”). Manual closure of the outlet forces gas to flow through the side tube (“inspiration”).

Results and Discussions: Blood gas values (pO₂/pCO₂ in kPa) were, respectively: after equilibration: 25.5/4.8; after 10 min ventilation using an oxygen flow of 10 L/min: 71.4/9.2; 20 min: 71.4/11.4; 30 min: 67.8/12.6. After 20 min equilibration (25.1/5.1), flow was increased to 14 L/min and blood gas analysis showed the following values: 10 min: 78.1/8.4; 20 min: 76.2/8.6 and 30 min: 78.7/9.5. We demonstrated that sufficient oxygenation of an animal can be provided using our venturi emergency ventilation apparatus, though pCO₂ may increase. Higher oxygen gas flows may help to diminish this problem, which might be of limited relevance in the emergency situation anyway.

Conclusions: We provide a simple emergency transtracheal ventilation device, which satisfactorily performs in vivo.

Acknowledgements: This study was supported in part by a grant from the Ministry of Education, Sciences and Culture Mecklenburg-West Pomerania to KM (HWP-MV 2000).

A-702
Percutaneous transtracheal jet ventilation compared with a new oxygen flow modulator in a pig airway salvage model
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Background and Goal of Study: Percutaneous transtracheal ventilation is an effective way for oxygenation in the “cannot intubate, cannot ventilate” situation. Whereas percutaneous transtracheal jet ventilation (PJV) depends on special equipment (e.g. a hand triggered emergency jet injector), the oxygen flow modulator (OFM) is a new small device, which can simply be connected to a transcricothyroidal needle and a low pressure oxygen supply. We compared PJV and OFM in pigs allowed to desaturate to 70% SpO₂ due to respiratory arrest.

Materials and Methods: With approval of the animal protection committee 8 pigs (31 ± 3 kg) were anaesthetized and paralyzed, intubated and ventilated. After instrumentation an emergency transtracheal airway catheter was inserted into the trachea. Then ventilation was stopped. When SpO₂ reached 70% the pig was ventilated after a blood gas analysis for 10 min in random order with OFM or PJV. Then ventilation was stopped again until SpO₂ reached 70% before the pig was ventilated with the second device. Wilcoxon test was used for statistical analysis and P < 0.05 was considered significant.

Results and Discussions: With both devices the animals were resuscitated with success: Whereas PaO₂ differed not significantly between the two devices, PaCO₂ was lower during PJV with the oxygen flow modulator.

Conclusions: The efficacy of the oxygen flow modulator during the experiment was comparable with the efficacy of the hand triggered emergency jet injector.

Reference:
Results and Discussions: 297 patients (132 = 2g; 132 = 1g; 33 = placebo) were randomized. TOTPAPR6 was significantly superior with 2g: 10.2 ± 6.5 versus 1g: 7.1 ± 5.9 versus placebo: 2.8 ± 4.4 (p < 0.0001). Comparable results were observed over 8 h. Pain relief and pain intensity difference scores of 2 g were significantly superior to 1 g from T30' to T8 h and to placebo from T15' to T8 h. Median time to remedication was significantly longer with 2g: 5 ± 0.2 min, versus 1g: 3 ± 14 min, placebo: 1 ± 02 min. No statistically significant difference was observed between the 3 groups regarding the safety profile.

Conclusions: A superior analgesic efficacy of 2 g of injectable paracetamol over the recommended dose of 1 g was demonstrated following third molar surgery in terms of magnitude and duration of analgesic effect, with no difference in terms of safety between groups.

Acknowledgement: Supported by a grant from Bristol-Myers Squibb/UPSA.

A-705
Modulation of remifentanil-induced analgesia and post-injection hyperalgesia by parecoxib in humans

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Background and Goal of Study: In previous works we showed the existence of opioid-induced hyperalgesia after short-time infusion of remifentanil in an experimental human pain model (1). Furthermore, in the same model, inhibition of central COX was identified as an important mechanism of NSAID-mediated antihyperalgesia in humans (2). Thus, the aim of the investigation was the determination of anagrelgic and antihyperalgesic properties of parecoxib on remifentanil-induced hypersensitivity.

Materials and Methods: Fifteen healthy volunteers were enrolled in this double blind and placebo controlled study in a cross-over design. Transcutaneous electrical stimulation at high current density (31.2 ± 14.6 mA) induced spontaneous acute pain (NRS = 6 of 10) and stable areas of hyperalgesia for painful mechanical stimuli to pinprick and touch. Pain intensity as well as the extent of the areas of hyperalgesia were assessed before, during and after 30 min lasting intravenous infusions of remifentanil (0.1 µg/kg/min) or placebo (NaCl 0.9%). A group of 20 minutes lasting intravenous infusion of parecoxib (40 mg) or placebo (NaCl 0.9%) was added either with the onset of electrical stimulation (preventive) or with the start of the remifentanil infusion (parallel). The assessments were separated by 2 weeks wash-out periods.

Results and Discussions: As shown before, remifentanil reduced pain and mechanical hyperalgesia during the infusion, but upon withdrawal, pain and hyperalgesia increased significantly above control level. Preventive administration of parecoxib led to an amplification of remifentanil-induced antinociceptive effects during the infusion (71.3 ± 17% vs. 46.4 ± 17% of control) and diminished significantly the hyperalgesic response after termination of the infusion. In contrast, parallel administration of parecoxib did not show any modulatory effects on remifentanil-induced hyperalgesia.

Conclusions: Parecoxib significantly attenuated remifentanil-induced hyperalgesia in a human pain model, confirming parallel processing of transduction signaling of µ-opioids and prostaglandins (3). Furthermore, adequate timing seems to be of particular importance for the antihyperalgesic effects of COX-2 inhibitors.

References:

A-706
Cannabinoid plasma levels and side effects after oral application of cannabis extract: a randomised, active placebo-controlled, crossover study in healthy volunteers

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Introduction: Delta-9-THC (Marinol®) has been approved for the treatment of HIV-wasting syndrome, and for nausea and vomiting in cancer patients. The significant first-pass-effect of oral cannabinoids and their highly variable gastrointestinal absorption make it difficult to predict dose-related cannabinoid effects in patients. In our study, we investigated plasma levels of orally administered cannabis extract and the most common side effects in a homogenous group of volunteers.

Methods: Capsules, containing cannabis extract standardised on its Delta-9-THC-content (20 mg THC each, THC:CBD= 2:1) or placebo (5 mg diazepam) were administered orally together with a standardised breakfast to healthy female volunteers (n = 16) history in a randomized, double-blind, placebo-controlled crossover design. Plasma levels of THC, cannabidiol (CBD) and the two active metabolites THC-11OH and THC-COOH were measured before, 2, 4 and 8 hours after administration of the drugs. The major THC side effects, sedation, “feeling high”, vertigo, dry mouth etc. were determined every 60 min for an 8 h period by both the individual and an observer using 11-point visual analogue scales (self-rating VAS and observer VAS), SaO2, RR, heart rate and body temperature were measured every 30 min.

Results: In 12 probands (75%) peak plasma levels of THC and CBD were reached within 2 hrs, in 25% (n = 4) between 2 and 4 hrs after administration, showing THC values between 1.29 ng/ml and 7.91 ng/ml. Peak values of CBD and the THC metabolites showed a similar variance. The maximum VAS for all side effects was seen at 2.6 hrs after drug administration and was significantly enhanced compared to baseline and placebo. However, no correlation was found between the magnitude of the subject’s individual plasma level and the intensity of the side effects. Only heart rates were significantly elevated, the systolic RR measurements were lower in the cannabis group, diastolic RR, body temperature and SaO2 remained unaltered.

Conclusions: Even under well controlled, standardised conditions, plasma levels and bioavailability of orally administered cannabinoid preparations are highly variable. These results further confirm the clinical observation that cannabinoid effects after enteral administration are not clearly dose-related and may considerably vary in each individual. Therefore we conclude that for the design of future clinical studies on therapeutic cannabinoid effects, the individual titration in each subject should be considered an essential part of the protocol.

Acknowledgement: This project was supported by “Fonds Soziales Wien”.

A-707
Effect of oral cannabis extract on the development of spontaneous pain and hyperalgesia after intradermal capsaicin injection in humans: a placebo-controlled, randomised crossover study

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Introduction: Analgesic and anti-hyperalgesic properties of cannabinoids have been demonstrated in numerous animal models. The objective of our study was to investigate the effects of orally administered cannabis extract on pain response and hyperalgesia in healthy volunteers by intradermal injection of capsaicin.

Methods: Healthy female volunteers (n = 16, median age 23y, median BMI 22) were randomised for this double-blind, cross-over study. Capsules containing cannabis extract standardised on its Delta-9-THC content (20 mg THC, THC:CBD = 1:2) or active placebo (5 mg diazepam) were administered orally together with a standard breakfast:150 min after medication, 20 µl of 0.1% capsaicin were injected intradermally into one forearm. Using an 11-point visual analogue scale (VAS), the initial pain intensity and its decrease were determined at 15 s intervals for the first 2 min, followed by measurements at 2.5, 9 and 15 min after injection. The flare area was assessed by tracing on an acetate sheet 10 min after injection. The hyperalgesic area was determined by pinprick and brush.

Results: Maximum pain intensity was measured immediately after capsaicin injection and disappeared almost completely within 15 min. There was no significant difference in spontaneous pain intensity between both groups, but pain decreased more rapidly under cannabis compared to placebo. Cannabinoid medication had no influence on the flare area or the area of hyperalgesia.

Discussions: Intradermal administration of capsaicin leads to a rapid onset neurogenic inflammation with a local erythema due to the release of neuropeptides from nociceptive nerve endings. The spontaneous pain immediately after capsaicin injection is followed by a secondary mechanical hyperalgesia resulting mainly from central sensitisation. Rukwied et al. described that hyperalgesia after topically administered capsaicin could be significantly attenuated compared to baseline and placebo. However, no correlation was found between the magnitude of the subject’s individual plasma level and the intensity of the side effects. Only heart rates were significantly elevated, the systolic RR measurements were lower in the cannabis group, diastolic RR, body temperature and SaO2 remained unaltered.

Conclusions: Even under well controlled, standardised conditions, plasma levels and bioavailability of orally administered cannabinoid preparations are highly variable. These results further confirm the clinical observation that cannabinoid effects after enteral administration are not clearly dose-related and may considerably vary in each individual. Therefore we conclude that for the design of future clinical studies on therapeutic cannabinoid effects, the individual titration in each subject should be considered an essential part of the protocol.

Acknowledgement: This project was supported by “Fonds Soziales Wien”.

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A-709
Cell therapy for management of chronic pain
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Background and Goal of Study: Adrenal medullary transplants into the spinal cord subarachnoid space have been demonstrated to reduce pain sensitivity (1). In this study, we observed results from the release of non-narcotic substances, particularly catecholamines and opioid peptides from the transplanted cells into the CSF of the spinal cord. In our laboratory, not to be bothered by immune reaction, chromaffin cells were encapaculated with alginate. Catecholamines and met-erkenphalin from encapsulated chromaffin cells were measured quantitatively in vitro. The neurotransmitters were also measured more directly from adrenal medullary transplants in the spinal cord CSF.

Materials and Methods: Isolated bovine chromaffin cells were encapsulated with alginate and poly-L-lysine prior to implantation into rat subarachnoid space to protect them from host immune system. And then catecholamines and met-erkenphalin from encapsulated chromaffin cells were measured quantitatively in vitro by HPLC and RIA (Radioimmunoassay) respectively. The animals were randomized into 2 groups, one of which received micronecapsulated chromaffin cells and the other empty capsules. The effects of such implants were evaluated on the pain behavior resulting from a chronic constriction injury of the rat sciatic nerve for 30 days. After sampling CSF of rats catecholamine concentration in CSF was analyzed. Data (mean ± SD) are considered significant at a P < 0.05 (ANOVA for repeated measure and Dunnett's test).

Results and Discussions: After nicotine stimulation, release of catecholamine and met-erkenphalin from encapsulated cells was demonstrated. A significant reduction of alldynic response to acetone evaporation was observed in the animals implanted with capsule group compared to empty capsule group. The retrieved chromaffin cells maintain their morphology. Catecholamine concentration in CSF is higher in the cell loaded capsule group. There are no complications related to implantation.

Conclusion(s): In conclusion, we found that encapsulated chromaffin cells remained viable after implantation into the subarachnoid space of rats and produced analgesic effects in a model of neuropathic pain. In the future, further investigation of the production of analgesic substances in the CNS and more intensive immunological studies are required.

Reference:

Acknowledgements: This study was supported by a grant of the International Mobile Telecommunication 2000 RND Project, Ministry of Information & Communication, Republic of Korea.

A-710
Pain stimulation by using synchronised somatosensory evoked potentials (SSEPs) and contact heat evoked potentials (CHEPs)
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Background and Goals: Non painful stimuli are transmitted over large A-beta fibres. Somatosensory evoked potentials (SSEPs) evaluate conduc- tion of these fibres after an electrical stimulation of peripheral mechanoreceptors(1). Noiceptive stimuli generate action potentials in nociceptors, which have a higher stimulation threshold and which are associated to thinner A-delta and C nerve fibres, characterised by slower conduction velocities due to minimal or absent myelination(2,3). The goal of this study is to verify the feasibility of synchronised SSEPs and CHEPs in normal subjects, in order to create a new electrophysiological tool for clinical use. By using this kind of paradigm, we expect that we can monitor both the velocity of A-beta, and A-delta fibres at the same time.

Methods: 20 healthy normal subjects were investigated (13 females and 7 males). The galvanic stimulation for the SSEPs was applied on the right pos- terior tibia (1 mA, 30 ms). The CHEP trigenic was applied to the right S1 dermatome at a 52°C (inter-stimulus time: 15 sec; total number of stimuli: 90). A Visual Analogue Scale (VAS) was used to assess pain at the first stimuli and every 3 min thereafter. The acquisition was performed using a Micromed® EEG system Fz (A1–A2) and CPz (A1–A2) derivations. The average and single sweep analysis was performed in- and off-line.

Results: The group mean age and height was 25 ± 7 year and 176 ± 7 cm respectively. In all subjects, we observed a N1-P1 component with a latency of 564 ± 105 ms for N1 and 670 ± 121 ms for P1 that were corre- lated (r = 0.9). No significant variation of amplitude and latency over time was observed for the P1-N1 component (r = 0.9 single sweep analysis). In contrast, VAS decreased from 32.7 to 18.5 (> 42.2% and p < 0.01) and did not correlate with N1-P1 latencies component (r = −0.2).

Conclusions: By using synchronised evoked SEP and CHEP stimuli a N1-P1 component was observed on the scalp in a normal group of volunteers at a latency of 564–670 ms on F2 and CP2. These components may reflect the actionings of the A-Delta fibres in the 1st dermatome. The decrease of VAS during the period of stimulation may reflect the cognitive adaptation to pain over time. We conclude that combined SEP and CHEP stimulation may be helpful to monitor A-Beta, A-Delta and C fibres before, per and after surgery and perhaps during anaesthesia induction.

References:

A-711
The antiallodynic effect of intrathecal A1, A2 and A3 adenosine receptor agonists in rats with nerve-ligation injury
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Background and Goal of Study: Peripheral nerve injury may result in chronic neuropathic pain, which is characterized by spontaneous pain, hyperalgesia, and allodynia. In the present study, we sought: 1) to investigate the spinal pharmacology of A1, A2, and A3-selective adenosine receptor agonist; and 2) to define the receptor pharmacology of spinal effects on the antiallodynic action and motor dysfunction using Rats with nerve-ligation injury.

Materials and Methods: The left L5 and L6 spinal nerve roots were ligated and, 1 week later, an intrathecal catheter was inserted in male rats. Withdrawal threshold to mechanical stimulation of the left hind paw was determined before and after surgery, confirming mechanical allodynia. The antiallodynic effects of intrathecal A1, A2, and A3 adenosine agonists were determined, and reversal of the effects of adenosine agonists by selective adenosine antagonists was tested. We assessed the motor function in a simple manner by grading the ambulation behavior of rats as the following: 2 = normal; 1 = limping; 0 = paralyzed. The rats were tested for 10 min once every test period.

Results and Discussions: Intrathecal administration of the A1 adenosine agonist produced a dose-dependent antiallodynic action and evoked a motor weakness at a dosage of 30 µg. Intrathecal A2 and A3 adenosine agonist also produced a dose-dependent reduction in allodynia and this effect was associated at 300 µg respectively after a short interval with prominent hind limb weakness. Intrathecal pretreatment with the A1 adenosine-selective antagonist (100 µg) blocked the antiallodynic effect of A1 adenosine agonist (10 µg). The A2 adenosine-selective antagonist (100 µg) prevented the antiallodynic effects of the A2 adenosine-selective agonist (30 µg). The A3 adenosine-selective antagonist (100 µg) prevented the antiallodynic effects of the A3 adenosine agonist (30 µg). Pretreatment with the A2 adeno- sine-selective antagonist (300 µg) prevented the motor dysfunction induced by A1 (30 µg), A2 (300 µg), and A3 (300 µg) adenosine agonist.

Conclusion(s): We suggest that the antiallodynic effects of the A1, A2, and A3 adenosine-selective agonists are mediated through the activation of spinal A1 adenosine receptors and motor dysfunction effects are mediated through A2 adenosine receptors.

A-712
Clonidine effect on pain after pediatric tonsillectomy: systemic versus local administration
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Background: Children experience significant pain after tonsillectomy. Clonidine (CLO), an alpha2-adrenergic agonist, exhibits analgesic and anti-inflammatory effects in the perioperative period (1). Early benefit (-48h) of systemic CLO is controversial after pediatric tonsillectomy (2) while local administration reduces postoperative pain (3). This study evaluates late benefit of CLO administration and questions a local effect.

Materials and Methods: Children (ASA 1–2; age 2 to 12 yr; n = 10 per group) allocated for tonsillectomy randomly received: intravenous (IV) and local saline (IV saline), or IV CLO 2 µg/kg and IV saline (local CLO), parenteral saline (IV saline), or IV CLO 2 µg/kg and IV saline (local CLO). General anesthesia was similar with sevoflurane inhalation, sufentanil 0.25 µg/kg and IV paracetamol 15 mg/kg. Postoperative pain and analgesics...
needs, after evaluation at day 0, were assessed by the parents at day(D1), D2, D5 and D7 using Objective Pain Scale (5 pts: 1 = no pain, 5 = strong pain relieved by treatment). Analgesics needs were left at their discretion (paracetamol, diclofenac). Statistical analysis used ANOVA, Kruskall-Wallis, P < 0.05 significant.

Results: Groups did not differ for age (average 4 ± 1.5 yr), weight, intraoperative parameters, pain and analgesics at D0. Long-term parameters D1 until D7 are in Table: pain scores and cumulative (T) doses of analgesics (mean ± SD).

<table>
<thead>
<tr>
<th></th>
<th>Saline</th>
<th>IV CLO</th>
<th>Local CLO</th>
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<tbody>
<tr>
<td>Pain score D1</td>
<td>3.5 ± 1.2</td>
<td>3 ± 1.3</td>
<td>2.9 ± 0.7</td>
</tr>
<tr>
<td>Pain score D2</td>
<td>3.5 ± 1.1</td>
<td>1.8 ± 1.3</td>
<td>2.7 ± 0.7</td>
</tr>
<tr>
<td>Pain score D5</td>
<td>3.6 ± 1.2</td>
<td>1.7 ± 0.5*</td>
<td>2.2 ± 0.9*</td>
</tr>
<tr>
<td>Pain score D7</td>
<td>2.6 ± 1.5</td>
<td>1.8 ± 1.3</td>
<td>1.8 ± 0.7</td>
</tr>
<tr>
<td>T paracetamol</td>
<td>6.6 ± 3</td>
<td>9.1 ± 4</td>
<td>5 ± 1**</td>
</tr>
<tr>
<td>T diclofenac</td>
<td>7.9 ± 5</td>
<td>5.7 ± 3</td>
<td>4 ± 3</td>
</tr>
</tbody>
</table>

P < 0.05 with (*Saline, **)IV CLO; (#) P < 0.09 with Saline.

Discussion and Conclusion: Systemic CLO during tonsilllectomy reduces postoperative pain at D2 and D5. These results and others (3) showing lower pain scores at D3 and D5 after local ropivacaine-clonidine infiltration plaid for a local CLO effect deserving additional studies.

References:

A-713

A systematic review of single dose glucocorticoid for postoperative pain
L. Romundstad, H. Breivik, A. Stubhaug for ESA Open Forum on Postoperative Pain Management
Department of Anaesthesiology, Rikshospitalet, University of Oslo, Dept Group of Clinical Medicine, Oslo, Norway

Background and Goal: Glucocorticoids have been used for postsurgical pain relief. We evaluated randomized controlled studies (RCT) on single-dose perioperative glucocorticoid for reduction of post-operative pain.

Materials and Methods: Search strategy: We searched the Cochrane Library (Issue 4, 2004); MEDLINE (1966 – December 2004); EMBASE (1980 – December 2004); PubMed (1970 – December 2004) and reference lists of relevant articles. Selection criteria: Randomized, double-blind, placebo-controlled clinical trials of a single-dose of a glucocorticoid on acute post-operative pain in adult or pediatric patients. Analysis: Forty two RCTs of sufficient quality were identified. Quantitative analysis was not performed due to varied outcome variables.

Results and Discussions: Glucocorticoids were significantly superior to placebo after oral, orthopaedic and spinal surgery (19 of 22 RCTs), after ENT surgery (4 of 10 RCTs). After major abdominal surgery, glucocorticoids were not superior to placebo in any of the 7 included trials. In the only RCT in laparoscopic cholecystectomy dexamethasone significantly reduced pain compared with placebo. After major thoracic surgery one RCT demonstrated analgesic effect compared with placebo (after lung surgery) and one RCT did not (after heart surgery).

Conclusions: Single doses of a glucocorticoid are clearly effective for post-operative pain after oral, orthopaedic and spinal surgery. After major abdominal and thoracic surgery the analgesic effect is not well documented.

Acknowledgement: This project is sponsored by an un-restricted educational grant from Bristol-Myers Squibb.

A-714

Chronic pain and hypersensitivity after cosmetic augmentation mammoplasty: effects of methylprednisolone, parecoxib, and placebo
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Department of Anaesthesiology, Rikshospitalet, University of Oslo, Dept Group of Clinical Medec, Oslo, Norway

Background and Goal: Chronic postsurgical pain is a major health care problem. The effects of methylprednisolone, parecoxib, and placebo on chronic pain and sensory dysfunction were studied after cosmetic augmentation mammoplasty.

Materials and Methods: A randomized, double blind study of 219 patients who received a single i.v. dose of methylprednisolone 125 mg (n = 74), parecoxib 40mg (n = 71), or placebo (n = 74) before breast augmentation surgery. A questionnaire was mailed 2 and 12 months after surgery.

Results: Methylprednisolone 125 mg or parecoxib 40 mg reduced acute pain compared with placebo. Response rate 12 months after surgery was 80%. 13% had non-evolved pain, 20% had evoked pain. Activities of daily life were affected in 14%. Hyperesthesia in the methylprednisolone group (30%) was reduced compared with placebo (56%; P < 0.01) and parecoxib (51%; P < 0.02). Predictors for pain at 1 year were intensity of pain during the first week after surgery (OR = 1.3; 95%CI = 1.1–1.6), pain at 2 months (OR = 18.4; 95%CI = 6.9–49.3), hyperesthesia at 2 months (OR = 2.3; 95%CI = 1.1–4.6) and present hyperesthesia (OR = 3.1; 95%CI = 1.4–6.7). Active drugs reduced the risk for evoked pain compared with placebo at 1 year (methylprednisolone, OR = 0.4; 95%CI = 0.2–0.9; parecoxib, OR = 0.4; 95% CI = 0.2–0.9). Methylprednisolone reduced the risk for hyperesthesia at 1 year (OR = 0.3; 95%CI = 0.1–0.8).

Conclusions: Persistent pain and sensory impairment are common after cosmetic augmentation mammoplasty. Predictors of pain after 1 year were pain during the first week and at 2 months after surgery. Both active drugs reduced the risk for evoked pain compared with placebo 1 year after surgery. Methylprednisolone, but not parecoxib resulted in less hyperesthesia after 12 months.

A-715

Pre-operative analgesic use of a selective COX-2 inhibitor (rofecoxib) in elective craniofibotomy
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Background and Goal of Study: Traditionally non-selective non-steroidal analgesics (NSAIDs) have been avoided in neurosurgery, because of their anti-platelet action1. Excessive opiate use can mimic or exacerbate neurologic complications. Codeine can be ineffective, but patient controlled analgesia (PCA) can be used safely2. Our study evaluates the analgesic benefits of adding a pre-operative dose of a COX-2 selective NSAID (rofecoxib) in patients undergoing craniofibotomy.

Materials and Methods: 42 patients were recruited to a double blind, randomised, placebo controlled study. Patients were allocated to receive 50 mg Rofecoxib (group R) or placebo (group P), 1 hour prior to elective craniofibotomy. All patients received regular paracetamol, and PCA morphine post operatively. Pain scores (VAS), morphine consumption (mg), sedation, nausea and Glasgow Coma scores were recorded at 30 minutes, 2,6,12 and 24 hours post operatively.

Results and Discussion: The trial was completed by 19 patients in the Rofecoxib group [mean age 45 (range 18–65)] and 15 in the placebo group [mean age 46 (range 25–71)]. There were no significant differences found in morphine consumption (using Mann-Whitney U test), pain scores or complication rate at any time during the 24 hr study period. The table below shows mean morphine consumption (mg ± SD).

<table>
<thead>
<tr>
<th></th>
<th>Group P</th>
<th>Group R</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 mins</td>
<td>1.4 ± 1.9</td>
<td>2.3 ± 2.0</td>
<td>0.56</td>
</tr>
<tr>
<td>2</td>
<td>5.8 ± 4.7</td>
<td>6.1 ± 4.8</td>
<td>0.78</td>
</tr>
<tr>
<td>6</td>
<td>12.9 ± 10.9</td>
<td>12.9 ± 9.1</td>
<td>0.70</td>
</tr>
<tr>
<td>12</td>
<td>18.1 ± 16.2</td>
<td>19.6 ± 16.5</td>
<td>0.78</td>
</tr>
<tr>
<td>24</td>
<td>29.6 ± 25.9</td>
<td>28.4 ± 23.2</td>
<td>0.88</td>
</tr>
</tbody>
</table>

Haemostasis was reported difficult in 2 patients in group P compared to 1 in group R.

Conclusion: The use of rofecoxib in a single preoperative dose, although apparently safe, cannot be recommended for analgesic use in craniofibotomy, as it confers no benefit compared with placebo.

References:

A-716

Effects of clonidin on postoperative pain depend on trait anxiety
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Background and Goal of Study: Trait anxiety influences the coping with postoperative pain (1). Individual differences of coping and its consequences on aspects of stress are well described by Lazarus (2). The purpose of this study was to evaluate the influence of trait anxiety on pharmacological effects (clonidin) with respect to postoperative pain.
Materials and Methods: After IRB improv and written informed consent 28 patients awaiting lumbar disc surgery were randomly assigned to receive double blind either clonidin (0.6 µg/kg/h) or placebo intraoperatively. Anaesthesia was induced and maintained using remifentanil and propofol. Trait anxiety was evaluated using the trait form of the Spielberg State-Trait Anxiety Inventory (STAI-G X2). The sample was shifted at the median of the test sum score to form two groups of patients those with a higher level of trait anxiety and those with a lower level of trait anxiety. Postoperative pain management was carried out with patient controlled analgesia using piritramid. Pain scores were measured using a visual analog scale. Postoperative aspects of mood were measured using a multidimensional rating scale. Statistical analysis was performed using analysis of variances. Statistical difference was assessed by post hoc Tukey's test. The elevated PGE2 levels in cerebrospinal fluid (CSF) following formalin-induced inflammation. Therefore, the role of lidocaine alone on spinal prostaglandin E2 (PGE2) release was further investigated.

Materials and Methods: Spinal loop microdialysis catheters were implanted in adult male Wister rats. The microdialysis experiments were performed in freely-moving rats following 6 days of recovery. After 1 h baseline sampling at flow rate of 10 µl/min, 50 µl of 2% lidocaine or saline was given intrathecally. Diallysates were further collected for another 5 h and PGE2 concentrations were analysed by ELISA. Statistical difference was assessed by one-way ANOVA for repeated measures.

Results and Discussions: Intrathecal injection of lidocaine resulted in a significant increase in PGE2, to 287.8 ± 57.0% of their baseline values within 20 min, although it totally blocked the sensory input. The elevated PGE2 might contribute to the development of hyperalgesia.

Acknowledgement: The study was supported by a departmental fund.

A-718

Treatment with parenteral parecoxib followed by oral valdecoxib after major general surgery reduces opioid consumption and opioid-related adverse effects

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Background and Goals: COX-2 selective inhibitors may provide well-tolerated perioperative analgesic efficacy when administered alone or as multimodal therapy.

Materials and Methods: Postoperative opioid consumption and patient-reported opioid-related adverse symptoms were assessed in this randomized, double-blind, placebo-controlled trial of patients who had undergone major general surgery (gastrointestinal, orthopedic, gynecologic, urologic, and thoracic). Patients were randomized to parecoxib (PAR)/valdecoxib (VAL) (n = 533; PAR 40 mg IV loading dose on Day 1 followed by PAR 20 mg IV/IM q12 h for > 3 days then oral VAL 20 mg q12 h for 7 days) or matching placebo (PBO) (n = 529). Supplemental analgesia was patient-controlled morphine during IV/IM dosing, and codeine/acetaminophen or hydrocodone/acetaminophen during oral dosing, expressed in morphine equivalents (mg). Frequency, severity, and bother domains of 10 opioid-related adverse effects (fatigue, drowsiness, inability to concentrate, nausea, dizziness, constipation, itching, difficulty urinating, confusion, and retching/vomiting) were evaluated on Days 2 through 10 using the Opioid-Related Symptom Distress Scale (OR-SDS) patient-reported instrument. Symptoms at the upper distress continuum of frequency, severity, or bother were defined as clinically meaningful events (CMEs).

Results and Discussion: The PAR/VAL group showed a 35% reduction (P < 0.001 vs PBO) in cumulative Day 1 through 10 morphine equivalents. On Days 2 through 10, OR-SDS-measured total-symptom frequency, severity, and bother distress were reduced by 26%, 27%, and 24%, respectively (nominal P < 0.001 vs PBO) in the PAR/VAL group. Risk of experiencing a CME was reduced for 8 of 10 symptoms, and the PAR/VAL group was less likely to experience a CME day with >1, >2, and >3 of the symptoms (nominal P < 0.001). PAR/VAL prevented 21%, 29%, and 39% of potential CME days with >1, >2, and >3 of symptoms, respectively.

Conclusions: Treatment with PAR/VAL, compared with PBO, significantly reduced opioid consumption. Clinical benefits included reduced opioid-related symptom distress and significantly fewer patient days with opioid-related CMES.

Acknowledgement: Sponsored by Pfizer Inc.

A-719

The different roles of the spinal protein kinase Cδ and γ in morphine dependence and naltroxone-precipitated withdrawal

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Jiangsu Institute of Anesthesiology, Affiliated Hospital of Xuzhou Medical College, Xuzhou, China

Background and Goal of Study: This study was to investigate the roles of spinal protein kinase C (PKC) δ, γ in morphine dependence and naltroxone-precipitated withdrawal.

Materials and Methods: To set up morphine dependence model, rats were subcutaneously injected with morphine (twice a day, for 5 d). The dose of morphine was 10 mg/kg in the first day and was increased by 10 mg/kg each day. On day 6, 4 h after the injection of morphine (50 mg/kg), morphine withdrawal syndrome was precipitated by an injection of naltroxone (4 mg/kg, i.p.). Chelerythrine chloride (CHE), a PKC inhibitor, was intrathecally injected 30 min before the administration of naltroxone. The scores of morphine withdrawal symptom and morphine withdrawal-induced allodynia were observed. One hour after naltroxone-precipitated withdrawal, Fos protein expression was assessed by immunohistochemical analysis and western blot was used to detect the expression of cysotol and membrane fraction of PKC δ and γ in the rat spinal cord.

Results and Discussion: The results showed that intrathecal administration of CHE decreased the scores of morphine withdrawal, attenuated morphine withdrawal-induced allodynia and also inhibited the increase of Fos protein expression in the spinal cord of morphine withdrawal rats. The expression of cysotol and membrane fraction of PKC δ was significantly increased in the spinal cord of rats with morphine dependence. Naltroxone-precipitated withdrawal induced PKC δ translocation from cytosol to membrane fraction, which was prevented by intrathecal administration of CHE. During morphine dependence, but not naltroxone-precipitated withdrawal, PKC γ in the spinal cord translocated from cytosol to membrane fraction,
and intrathecal administration of CHE did not change the expression of PKC γ in the spinal cord of naloxone-precipitated withdrawal rats.

**Conclusion(s):** It is suggested that up-regulation and translocation of PKC in the spinal cord contribute to morphine dependence and naloxone-precipitated withdrawal in rats and that PKC α and γ play different roles in the above-mentioned effect.

**A-720**

**Effects of intermittent hemodialysis on buprenorphine and norbuprenorphine plasma concentrations in chronic pain patients treated with transdermal buprenorphine**

J. Filitz, N. Grießinger, R. Sittl, R. Likar, J. Schützler, W. Koppert  
Department of Anaesthesiology, University Hospital Erlangen, Erlangen, Germany

**Background and Goal of Study:** The use of opioids in patients with general and end-stage renal disease is often associated with an increased risk of side-effects. Thus, a dose adjustment is recommended for several agents in this class. On the other hand, opioids are often removed by hemodialysis leading to uncertain analgesic effects. The present study was designed to study the impact of intermittent hemodialysis on the disposition of the buprenorphine and its metabolite norbuprenorphine in chronic pain patients with end-stage kidney disease.

**Materials and Methods:** After approval of the local ethics committee, 10 patients with a need for a pain therapy according to step 3 of the WHO analgesic ladder were included in the study (mean age: 57.4 ± 14.1 years). Before enrolment in the study the opioid therapy was switched to transdermal buprenorphine (Transtec®, Gruenenthal GmbH, Aachen, Germany), starting with about 50% of the equipotent opioid dose. Transdermal buprenorphine was increased stepwise until the average pain score as measured by using a numeric rating scale (NRS 0–10) was below 4. At least one week later, the patients were asked to provide blood samples for analyses immediately before and after hemodialysis.

**Results and Discussions:** The median buprenorphine plasma concentrations were found to be 0.16 (0.10-0.52) ng/ml before and 0.23 (0.12-0.56) ng/ml after hemodialysis. A significant correlation between plasma levels and administered doses (51 ± 18 μg/h) was observed (Spearman R = 0.74; P < 0.05). In three patients, no buprenorphine plasma levels were detected (<0.05 ng/ml). No differences in pain relief before and after haemodialysis were observed.

**Conclusions:** Transdermal therapy with buprenorphine in chronic pain patients with end-stage kidney disease is an efficient and safe treatment option. Buprenorphine plasma levels in these patients are unaffected by haemodialysis, and neither buprenorphine nor the metabolite norbuprenorphine seem to accumulate, resulting in no need for any dose adjustment of transdermal buprenorphine in patients treated with intermittent haemodialysis.

**Acknowledgement:** The study was supported by the Gruenenthal Research Department, Aachen, Germany.

**A-721**

**Activation of naloxone-sensitive and -insensitive inhibitory systems in a human pain model**

Department of Anaesthesiology, University Hospital Erlangen, Erlangen, Germany

**Background and Goal of Study:** Endogenous pain inhibition is of major importance in chronic pain conditions and has also been shown to modulate pain and hyperalgesia in human experimental pain models. We investigated naloxone sensitivity of acute pain inhibition and possible lasting inhibition in a model of electrically induced pain and hyperalgesia.

**Materials and Methods:** In a double blind, placebo controlled, cross-over study fifteen volunteers underwent four 150 minute sessions of high current density electrical stimulation of their forearms. Two microdialysis fibres were inserted intradermally over a length of 1 cm at the central volar forearm of the subjects. Monophasic, rectangular electrical pulses of 0.5 ms duration were applied at 2 Hz via a constant current stimulator (Digitimer S7, Digitimer, Hertfordshire, UK). The current was gradually increased during the first 15 min of stimulus administration, targeting a pain rating of 6 (11-point scale; 0 = no pain and 10 = maximum tolerable pain) and then kept constant for the remaining time of stimulation. After 60 minutes, naloxone or placebo was given in a controlled infusion targeting increasing plasma concentrations of 0.1, 1.0, and 10 ng/ml (30 min. each) in three of the four sessions. The first three sessions took place once a week and the final session after 6 weeks. Pain ratings and areas of mechanical hyperalgesia were assessed at regular intervals during all sessions.

**Results and Discussions:** Pain ratings and areas of hyperalgesia significantly decreased during the sessions to 62%, 70% and 82% of the initial value for pain ratings, areas of punctate hyperalgesia and allodynia. Naloxone reversed this decrease for pain ratings as well as for hyperalgesia. While pain ratings remained constant from session to session, the areas of punctate hyperalgesia successively shrunk to 60% of initial value at the fourth repetition. The session effect was not reversed by naloxone.

**Conclusions:** We conclude that the high current density stimulation provoked central sensitization, but in addition, an acute naloxone-sensitive and a long term naloxone-insensitive inhibitory systems is activated. The long term inhibition may be associated with habituation which is known to modulate endogenous pain inhibitory systems.

**A-722**

**Quantification of analgesic and antihyperalgesic effects of buprenorphine and fentanyl in healthy volunteers**

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Department of Anaesthesiology, University Hospital Erlangen, Erlangen, Germany

**Background and Goal of Study:** We assessed the combination compatibility of the partial μ-agonist buprenorphine with the full μ-agonist fentanyl by quantifying their analgesic and antihyperalgesic effects when given either alone or in combination.

**Materials and Methods:** Fifteen healthy volunteers were included in this randomised, double blind, placebo controlled study. Transcutaneous electrical stimulation at high current density (38.4 ± 12.8 mA) induced spontaneous acute pain (NRS ~ 6 / 10) and stable areas of hyperalgesia for painful mechanical stimuli. Briefly, two microdialysis fibres were inserted intradermally over a length of 1 cm at the central volar forearm of the subjects. Monophasic, rectangular electrical pulses of 0.5 ms duration were applied at 2 Hz via a constant current stimulator (Digitimer S7, Digitimer, Hertfordshire, UK). The current was gradually increased during the first 15 min of stimulus administration, targeting a pain rating of 6 (11-point scale; 0 = no pain and 10 = maximum tolerable pain) and then kept constant for the remaining time of stimulation. Pain intensity as well as the extent of the areas of hyperalgesia were assessed before, during and after an i.v. infusion of 10 minutes’ duration of fentanyl (1.5 μg/kg), buprenorphine (1.5 μg/kg), their combination (0.75 μg/kg each) or placebo (saline 0.9%). Assessments were repeated every two weeks.

**Results and Discussions:** Fifteen minutes after fentanyl application and 45 minutes after buprenorphine application maximum analgesic effects were observed (pain reduction to 47 ± 23% and 59 ± 23%, respectively). The maximum effect of the combination (pain reduction to 58 ± 31%) occurred after 30 minutes and therefore fell between the maxima of single substances. During the whole observation period a supra-additive analgesic and an additive antihyperalgesic effect of both substances could be shown (analgesic effect: AUC fentanyl vs. buprenorphine vs. combination: 35.4 vs. 40.0 vs. 44.0; antihyperalgesic effect: AUC fentanyl vs. buprenorphine vs. combination: 18 vs. 25 vs. 23).

**Conclusions:** The combination of buprenorphine with the full μ-agonist fentanyl did not lead to any antagonistic effect in our model. On the contrary, both drugs seemed to reinforce each other in their analgesic and antihyperalgesic effects.
painful mechanical stimulus to pinprick and touch. Pain intensity as well as the extent of the areas of hyperalgesia were assessed before, during, and after 30 minutes lasting intravenous infusions of placebo (NaCl 0.9%), propofol (1.5 µg/ml), as well as combinations of propofol with the opioid remifentanil in two concentrations (0.025 and 0.05 µg/kg/min). The assessments were separated by two week wash-out periods.

### Results and Discussions

Propofol reduced significantly the electrically evoked pain to 75 ± 30% of control. Ninety minutes after completion of the infusion discrete analgesic effects (p < 0.1) were still detectable. Propofol alone did not lead to any hyperalgesic effects after termination of the infusion. The combination with remifentanil in both concentrations led to additive analgesic effects (52 ± 25% resp. 62 ± 26%), however, during the following 60 min. pain ratings increased and exceeded control values. Furthermore, the hyperalgesic areas remained significantly enlarged as compared to baseline values.

### Conclusions

Propofol led to a delay and a weakening of the remifentanil-induced hyperalgesia in humans. Nevertheless, pronociceptive effects were detected also after the combination with propofol, which may contribute to the increased post-operative demand for analgesics after remifentanil-based anaesthesia (1).

### References


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### Appendix A -724

#### Pre-emptive analgesia with combination of morphine and ketamine

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Department of Anaesthesiology and Intensive Care, Charles University in Prague, Czech Republic

#### Background and Goal of Study:

Many drugs have been used for pre-emptive analgesia, but their combination has been little studied. The aim of our study was to demonstrate that a pre-emptive combination of ketamine and morphine is more effective than when these drugs are administered separately.

#### Materials and Methods:

After ethic committee approval and patients’ consent a prospective blinded study was performed in patients elicited for abdominal hystereotomy with adnexectomy. Sixty three patients were randomly divided in equal groups. Group M was administered morphine 0.1 mg.kg–1 10 minutes before induction to general anesthesia (GA) and ketamine 0.6 mg.kg–1 10 minutes after laparotomy. Group K was administered ketamine 0.6 mg.kg–1 10 minutes before induction to GA and morphine 0.1 mg.kg–1 10 minutes after laparotomy. Group MK was administered morphine 0.1 mg.kg–1 and ketamine 0.6 mg.kg–1 10 minutes before induction to GA and NS 10 minutes after laparotomy. Postoperative morphine consumption was measured 24 and 48 hours after surgery using PCA device.

#### Results and Discussions:

There was significantly lower PCA morphine consumption in MK group compared to the other groups.

#### A-725

#### Co-administration of magnesium confers pain relief with reduced opioid requirement after cardiac surgery

B. Steinlechner, B. Birkenberg, M. Dworschak, G. Grubhofer, A. Schiferer, A. Rajek

Department of Anesthesia and General Intensive Care Medicine, University Hospital Vienna, Vienna, Austria

#### Background and Goal:

Magnesium prevents the induction of central sensitization from peripheral nociceptive stimulation (1). We hypothesized that perioperative treatment with magnesium gluconate would increase the analgetic potency of remifentanil given for pain management after cardiac surgery.

#### Materials and Methods:

In a randomized, double-blinded study 40 patients received remifentanil at 0.2–0.5 µg/kg/min intraoperatively. After induction of anesthesia, patients were either given magnesium gluconate (n = 20; 96.5 mg/kg bolus followed by a continuous infusion of 13.8 mg/kg/h) or placebo (n = 20). Remifentanil was titrated to effect as soon as pain could be evaluated by either a pain intensity score (PSI) in the intubated patient (range 1–6, 1 representing no and 6 unbearable pain) or later on by a color VAS scale (range 0–100, i.e. no and worst pain, respectively). A PSI ≥ 3 or a VAS > 30 induced increases of remifentanil by 0.01 µg/kg/min while a respiratory rate < 10 caused a decrease by the same magnitude.

#### Results:

Remifentanil was continued at a dose of 0.05 µg/kg/min in all our patients after arrival at the ICU. Dose adjustments because of insufficient pain control had to be made less frequently in magnesium treated patients before extubation (5 vs. 11 patients). Furthermore, magnesium significantly lowered the remifentanil requirement after extubation on average by 20% (P < 0.05), VAS score during the first 12 hours after extubation significantly dropped in the magnesium group from 15 to 1 and in the control group from 13 to 4 (P < 0.05), respectively. Dose reductions due to a respiratory rate < 10 had to be made 35 times in magnesium treated patients as compared to 23 times. Although magnesium serum levels were increased immediately after surgery (1.31 ± 0.25 vs. 0.8 ± 0.25, P < 0.05) it did not prolong time to extubation (134 ± 28 vs. 137 ± 21 min).

#### Conclusion:

Magnesium gluconate at the dosage we applied effectively reduced the remifentanil requirement for adequate postoperative pain management in patients after cardiac surgery. No serious side effects were observed.

#### Reference:


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### Appendix A-726

#### Concomitant use of non-opioid analgesics and morphine after major surgery – is there a clinically relevant morphine sparing effect? A meta-analysis of randomized trials

N. Elia, C. Lysakowski, M.R. Tramer

Department of Anaesthesiology, EBCAP, Geneva, Switzerland

#### Background and Goal of Study:

Concomitant use of non-opioid analgesics and morphine after major surgery is thought to decrease morphine consumption and the risk of morphine-related adverse effects, and to improve analgesia.

#### Materials and Methods:

We searched electronic databases, bibliographies, any language, to 7.2004 for randomized, placebo-controlled trials testing the efficacy of paracetamol, non-steroidal anti-inflammatory drugs (NSAID) or selective cyclo-oxygenase-2 inhibitors (Cox-2) given concomitantly with patient-controlled analgesia with morphine after major surgery, and reporting on cumulative 24 hours morphine consumption. A clinically relevant morphine sparing effect was defined as a decrease in the incidence of morphine-related adverse effects or as an improvement in analgesia. Data were combined using a fixed effect model, and were expressed as weighted mean difference (WMD), relative risk (RR), odds ratio (OR), and number-needed-to-treat/harm (NNT/H) with 95% confidence intervals (CI).

#### Results and Discussions:

We analyzed data from 50 trials (4661 patients). Median cumulative 24 hours morphine consumption in controls was 49 mg; it was significantly decreased with paracetamol (WMD, −8 mg), Cox-2 (−12 mg), and NSAID (−19 mg). Pain intensity at 24 hours was significantly reduced with NSAID (about 1 cm on the 10 cm VAS); with paracetamol, the effect was not significant, and for Cox-2, relevant data were scarce. With NSAID, the incidence of nausea/vomiting was reduced (RR 0.75, 95%CI 0.62–0.91; NNT 15), as was the incidence of sedation (RR 0.69, 0.54–0.88; NNT 37); the risk of serious bleeding complications was increased (OR 5.50, 1.30–23.3; NNH 50). Both NSAID and Cox-2 increased the risk of oliguria and renal failure.

#### Conclusions:

For concomitant NSAID only there is some evidence of a clinically relevant morphine sparing effect after major surgery. However, there is only little decrease in the incidence of morphine-related adverse effects, and the risk of potentially serious NSAID-related adverse effects is not negligible.

### Appendix A-727

#### Naloxone suppresses the pain relief effect of “cough-trick” during venipuncture: a crossover volunteer study


Department of Anaesthesiology and Intensive Care Medicine, Ernst Moritz Arndt University, Greifswald, Germany

#### Background and Goal of Study:

In previous study we have shown that the easily performed “cough-trick” (CT) reduced pain during...
A-728
Comparison of postoperative pain by different methods in the removal of gases after laparoscopic hysterectomy
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Background and Goal of Study: Laparoscopic surgery may allow a significant reduction in postoperative pain and analgesic consumption compared with conventional methods (1). Nevertheless, some patients still experience significant pain. We investigated degrees of postoperative pain and the incidences of shoulder pain versus the different methods of gas removal after laparoscopic hysterectomy.

Materials and Methods: Fifteen healthy male volunteers recruited according to inclusion criteria were blinded to the aim of the study. They were punctured with 20 G cannula in the dorsal vein of dominant hand without CT procedure and received 0.075 mg/kg intravenous opioid-receptor antagonist naloxone (NX). Thirty minutes after NX administration the dorsal vein of contra lateral hand was punctured with CT procedure. The intensity of pain during VP according to 100-mm visual analogue scale (VAS-100) was the primary end-point. The intensity of pain on pressure applied to glabella with the pressure probe of algesimeter (10 mm) was recorded before, 35 and 60 minutes after NX infusion.

Results and Discussions: Thirteen volunteers (age 25.3 ± 3.2 years; mean ± SD) finished the study. The intensity of VP pain with CT procedure after NX infusion was comparable with that without CT: 26 (16–38) vs. 22 (16–30) mm on VAS; median (interquartile range); P > 0.05. The pressure pain threshold decreased: 6.8 ± 2.3 vs. 6.2 ± 2.3 mm; P = 0.024; and the blood glucose concentration increased after NX administration: 4.9 ± 0.8 vs. 5.2 ± 0.8 mmol/L; P = 0.004; mean ± SD. The incidence of hand withdrawal reaction and sweating, blood heart rate, blood pressure increased after NX administration: 26 ± 7 vs. 24 ± 6; mean ± SD. *p < 0.05.

Conclusion(s): Endogenous opioid system might be involved in the analgesic mechanism of CT although the distraction effect should be excluded in the future study.

Reference:

A-729
Small dose ketamine does not reduce postoperative opioid analgesic requirements after cardiac surgery
Department of Anaesthesiology and critical care, Hospiten Rambla, Santa Cruz de Tenerife, Spain

Background and Goal of Study: Addition of a small dose of ketamine to opioids may increase the analgesic effect and prevent opioid-induced hyperalgesia and acute tolerance to opioids (1). We therefore tested the hypothesis that intraoperative small-dose ketamine improves postoperative analgesia after CABG with remifentanil-based anesthesia.

Materials and Methods: 50 patients scheduled for elective CABG were enrolled in this double-blind study under remifentanil-based anesthesia. They were randomly assigned to intraoperative ketamine or saline (control) supplementation. After induction of anaesthesia patients received the ketamine infusion 10 mcg/kg/min or saline infusion over the entire operation period. Analgesia was maintained with remifentanil, atracurium and a propofol infusion. All patients were given 0.15 mg/kg of morphine 45 min before the end of surgery. Pain scores and morphine consumption were recorded for 24 hours after surgery. Postoperative pain was treated with morphine, 3 mg of morphine was given IV at 5-min intervals. Data (mean ± SD) were analyzed by Student t-test, ANOVA and Mann Whitney U-test, with p < 0.05.

Results and Discussions:

<table>
<thead>
<tr>
<th>C Group</th>
<th>K Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time to first analgesic (min)</td>
<td>186 ± 27</td>
</tr>
<tr>
<td>Morphine (mg) consumption 24h</td>
<td>26 ± 7</td>
</tr>
</tbody>
</table>

Values are mean ± SD. *p < 0.05.

The Ramsay score was not different between the two groups. The incidence of side effects was comparable in the two groups.

Conclusion(s):
1) Small-dose ketamine did not decrease morphine consumption in CABG patients during the first 24 h after.
2) Ketamine increased significantly the time required until demanding the first dose of morphine postoperatively.

Reference:

A-730
Adrenaline improves the quality of patient controlled epidural analgesia after thoracotomy
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Background and Goal of Study: Thoracic epidural analgesia (EA) using continuous infusion of bupivacaine combined with fentanyl provides effective postoperative analgesia after thoracotomy (1). However, increased consumption of the preparations required for the adequate postoperative analgesia may lead to adverse effects. Adrenaline has been shown to reduce the risk of side effects during EA (2). Thus, the main goal of our study was to assess the patient controlled analgesia (PCEA) combining opioid-local anesthetic mixture and adrenaline administered after thoracotomy.

Materials and Methods: We enrolled 50 adult patients after major thoracic surgery in a prospective, randomized study. All patients were given PCEA using 0.125% bupivacaine and fentanyl (2 mcg/ml) either without (BF group, n = 25; 44.2 ± 1.9 yrs; 20 males/5 females) or with adrenaline (2 mcg/ml; ABF group, n = 25; 43.6 ± 2.1; 18 males/7 females). Pain scores were assessed in rest and coughing by 10-point visual analog scale (VAS) at 1, 3, 6, 12, 18, and 24 h after ICU admission. In addition, the consumption of drugs and the incidence of adverse effects (sedation, pruritis, urinary retention, nausea, and vomiting) were recorded. Data were compared using Student’s t-test and χ2 test, p < 0.05 was regarded as statistically significant.

Results and Discussions: VAS in coughing was significantly lower in the ABF group comparing with the BF group at 3, 6, 12, 18, and 24 h after ICU admission. The consumption of drugs required for the adequate analgesia (VAS < 3) decreased significantly in the ABF group as compared to the BF group and was 213 ± 4 vs. 225 ± 2 mg/24 hours and 319 ± 1 and 344 ± 3 mg/24 hours for bupivacaine and fentanyl, respectively. In the BF group we registered urinary retention, nausea, and vomiting in 24%, 20%, and 16% of the patients, respectively. Among these adverse effects, only one episode of pruritis was recorded in the ABF group.

Reference:
1 Student’s t-test and χ2 test, p < 0.05 was regarded as statistically significant
2 Test. p < 0.05.
Conclusion: After thoracotomy, PCEA using the combination of adrenaline with bupivacaine-fentanyl mixture reduces the consumption of both bupivacaine and fentanyl and declines the incidence of the adverse effects, therefore improving the quality of analgesia.

References:

A-731

Effect of preemptive administration of analgesics on surgery-induced tumor cells proliferation

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Background: Surgical stress and anesthesia interfere with immune system (1). Postoperative analgesia provided by morphine attenuates surgery-induced tumor proliferation (2). Because preemptive analgesia can contribute to reduce postoperative pain, our study assessed the preemptive effect of common analgesic drugs on surgery-induced tumor cells proliferation in a validated rat model of lung metastases (2).

Material and Methods: Adult male Wistar rats were assigned to different groups (n = 4–6 per group) and received either intraperitoneal (IP) saline (controls), ketamine 10 mg/kg, clonidine 10 µg/kg or fentanyl 40 µg/kg. In different animals, same IP drugs and doses were administered 30 min before an abdominal incision performed under sevoflurane anesthesia. In all the rats, tumor cells (MADB106, from rodent mammary adenocarcinoma) were intravenously injected in the tail 5 h after the aforementioned treatments as previously described (2). Three weeks later, animals were euthanized and lungs removed to allow a count of surface metastases. Statistical analysis used ANOVA and posthoc test, P < 0.05 was significant.

Results and Discussion: Metastases counts are expressed in Table as mean ± SD (95% CI).

<table>
<thead>
<tr>
<th>IP Saline</th>
<th>IP Ketamine</th>
<th>IP Clonidine</th>
<th>IP Fentanyl</th>
</tr>
</thead>
<tbody>
<tr>
<td>No surgery</td>
<td>21 ± 14 (11–31)</td>
<td>63 ± 30 (44–82)</td>
<td>23 ± 13 (11–36)</td>
</tr>
<tr>
<td>Abdom incision</td>
<td>51 ± 36 (20–82)</td>
<td>59 ± 24 (8–99)</td>
<td>44 ± 18 (21–66)</td>
</tr>
</tbody>
</table>

*P < 0.01; **P < 0.05 with no surgery-IP saline (controls).

Conclusion: In unoperated animal, only ketamine promotes tumor proliferation, an effect unrelated to NMDA antagonism but mediated through beta-adrenergic stimulation (3). In operated rats, incision by itself enhances tumor metastasis but pre-incisional administration of different analgesic drugs does not affect the immunosuppressive effect of surgical injury.

References:

A-732

Hypertensive patients have less postoperative pain than normotensives after laparoscopic cholecystectomy

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Background and Goal of Study: We compared the postoperative pain in hypertensive patients and normotensive patients after laparoscopic cholecystectomy.

Materials and Methods: This study was approved by our Ethics Committee. After obtaining informed consent, 24 ASA II-III patients were included in this study. The patients were randomized in two equal groups A (hypertensive patients) and B (normotensive patients). General anesthesia was induced with propofol (2.5 mg/kg), fentanyl (2 µg/kg), succinylcholine (1 mg/kg). Vecuronium (0.1 mg/kg) was used to facility mechanical ventilation and sevoflurane 1.5–2% for hypnosis. The pain score and the sedation score were done at 0, 30, 60 minutes, 4, 8, 12, 24 hours. Statistical analysis was performed using a two sides Student’s t test and the Mann Whitney U test (P < 0.05-statistical significance).

Results and Discussion: There were no significant differences in demographic data (age, sex, weight) surgical duration and anesthesia duration between the groups. No higher intraoperative incidence or adverse events were reported in both groups.

We measured pain at rest and on deep breath (10 point verbal numerical rating scale) for 1, 4, 6, 8, 12, 24 hours postoperatively in all patients. 40 mg pethidine was given whenever the pain score was smaller than 4 points.

The numbers of rescue analgesic pethidine doses were significantly lower in hypertensive than normotensive patients (80 ± 34 mg vs. 114 ± 29 mg).

The sedation score was higher in normotensive patients (group B) but not significantly (P > 0.05).

Conclusions: Hypertensive patients required less postoperative analgesic than normotensive patients after laparoscopic cholecystectomy.

References:

A-733

The effects of A1 adenosine receptor agonists, (R)-N6-(1-Methyl-2-phenethyl) adenosine (R-PIA) on the antiallodynic morphine tolerance in a rat model of postoperative pain

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Background and Goal of Study: Opioid tolerance is a diminution of analgesic effect or need for a higher dose to maintain the original effect following chronic opioid exposure. Opioid tolerance may be mediated by l-glutamate action. Adenosine receptors, probably of the A1 subtype localized in excitatory amino acid terminals, have been shown to inhibit the release of aspartate and glutamate. The effect of A1 adenosine receptor agonist, (R)-N6-(1-Methyl-2-phenethyl) adenosine (R-PIA) on opioid tolerance has not been studied. We investigated the hypothesis that R-PIA prevents and reverses chronic opioid tolerance.

Materials and Methods: Male rats were anesthetized with enflurane. An incision of the plantaris muscle of right hind paw induced mechanical allodynia. Withdrawal threshold to von Frey filament was determined. An intrathecal injection was performed and thresholds were determined. (1) Single intrathecal doses of 3 µg morphine, 20 µg R-PIA, and a combination of 3 µg morphine and 20 µg R-PIA were studied. (2) Rats received 3 µg morphine for 7 days. To evaluate the effect of R-PIA on development of morphine tolerance, R-PIA 20 µg was coinjected with morphine 3 µg for 7 days. To characterize the offset of the effect of R-PIA on morphine tolerance, R-PIA was coinjected with morphine for days 1–3 followed by daily morphine on days 4–7. (3) Morphine 3 µg was given for 4 days. On the following 3 days, R-PIA 20 µg was introduced in combination with morphine.

Results and Discussions: (1) Morphine or R-PIA alone produced antiallodynia. When given together, resulted in supra-additive antiallodynia. (2) Co-administration of morphine with R-PIA blocked the decrease in morphine effect throughout the entire 7 day period. Where R-PIA was co-administered with morphine for days 1–3, maximal antiallodynia with morphine was still observed on day 4, but a subsequent decrease in effect was observed from days 5 to 7. (3) Chronic administration of morphine on days 1–4 resulted in a decrease in antiallodynia. Addition of R-PIA on days 5–7 resulted in a partial restoration of the morphine effect and greater antiallodynia than for morphine alone on days 6 and 7.

Conclusion: This study suggests that R-PIA augments the antiallodynic action of both acute and chronic morphine therapy.

A-734

Auricular acupuncture reduces intraoperative fentanyl requirement during total hip arthroplasty – a randomised controlled study

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Background and Goal of Study: Auricular acupuncture (AA) has been shown to decrease desflurane requirement in healthy individuals [1]. We studied whether the AA of specific points can reduce intraoperative analgesic requirement during total hip arthroplasty (THA).

Materials and Methods: Sixty-four patients scheduled for elective THA were enrolled in this patient-anaesthesiologist-evaluator-blinded study according to inclusion criteria. The patients were randomly assigned to receive AA of specific points (Hip joint, Shenmen, Lung and Thalamus) or a sham procedure (4 non-biologically relevant points on the helix) ipsilateral to surgery site. Permanent press AA needles with the diameter of 0.22 mm and the length of 1.5 mm were placed and fixed with the adhesive tape in the evening before THA. The patients received standardised general anaesthesia, whereas...
end-tidal isoflurane concentration was kept constant within 0.8–1.0 vol.%. The fentanyl was titrated to prevent spontaneous movements during surgery and to maintain the heart rate and blood pressure within 20% of baseline values. Demographic data, intraoperative amount of fentanyl, end-tidal isoflurane, heart rate and blood pressure, body temperature and success of patients blinding were recorded.

Results and Discussion: Fifty-seven patients (30 in AA and 27 in the control group) completed the study. Patients from AA group required 21% less fentanyl during surgery than the controls: 3.9 ± 1.4 vs. 4.9 ± 1.2; mean ± SD; mcg/kg; P = 0.005. Demographic data, isoflurane end-tidal concentrations, duration of anaesthesia, intraoperative cardiovascular parameters, body temperature and patients’ opinion concerning the group allocation were comparable in both groups.

Conclusion(s): The study demonstrated that AA reduces intraoperative fentanyl requirement during total hip arthroplasty. Further large-scale investigation of this treatment modality comparing it with standard therapy and placebo acupuncture (non-inserted needle) appears to be necessary.


A-735
L-Arginine effects the somatosensory evoked responses of neurones in the rat substantia gelatinosa (SG) independent of changes in nitric oxide (NO) levels
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Background and Goal of Study: The amino-acid Arginine (Arg) is the substrate for nitric oxide synthesis. Any effects of arginine on neuronal activity is thus usually ascribed to an effect in stimulating NO formation. We have developed an electrochemical method (1), to measure extracellular NO levels with a microelectrode (CFM). The method allows for simultaneous recording of extracellular spike potentials from local cells together with the electrochemical signal. As part of the investigation we have applied Arg directly on the surface of the spinal cord above the microelectrode to ascertain whether this procedure would have an effect on NO synthesis.

Materials and Methods: Wistar rats were anaesthetized with fentanyl and urethane. The lumbar enlargement of the spinal cord was exposed surgically. Naflon-coated CFM were inserted in the cord (200–400 μm depth). Spikes from cells with low threshold receptive fields on the ipsilateral hindlimb were isolated and counted using a spike discriminator. Needle electrodes were inserted into the skin of the RF and used to deliver trains of electrical pulses (400 pulses at 50 Hz, 5 ms duration).

Results and Discussions: In 20 experiments the electrical stimuli generated a rise in extracellular NO (7.6 ± 0.24 μM, Mean ± SD). Mean spike count during stimulation was 548 ± 42 (Mean ± SD). After Arg there was no consistent change in NO release. But in 15 experiments (75%) Arg nearly abolished the spike activity in response to electrical stimulation (20 ± 2) (Mean ± SD). In no case was there any increase in spike activity following Arginine.

Conclusion(s): Our hypothesis is that GABA and Arg can both be taken up into cells by a similar transporter mechanism. A rise in extracellular Arg could reduce the GABA reuptake mechanism, leading to an increased inhibitory tone in the spinal cord. Arginine could thus act as a GABA synaptotropic modulator as well as being a substrate for NO synthesis.

Acknowledgement: This work was supported by a grant from the DFG.

A-736
Protocol design: a fentanyl HCl patient-controlled transdermal system (PCTS) vs. IV morphine patient-controlled analgesia for post-surgical pain management in 11 European countries
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Background and Goal of Study: Patient-controlled analgesia (PCA) allows patients to manage their postoperative pain effectively. Common routes of PCA administration are intravenous (IV) and epidural. However, postoperative pain continues to be undermanaged (1). The fentanyl HCl patient-controlled transdermal system (PCTS) provides a new alternative, noninvasive method to manage moderate-to-severe postoperative pain. The aim of this study is to compare the safety and efficacy provided by the PCTS with that of a standard regimen of IV PCA morphine following elective major abdominal or orthopaedic surgery.

Materials and Methods: An international, multicenter, open-label, randomized, active comparator, parallel-group study, with a total target enrollment of 650 patients, in 11 European countries. Treatment with the PCTS (40 μg fentanyl over 10 min; up to 6 doses/h for 24 h) or a standard regimen of IV PCA morphine (bolus doses, up to 20 mg per 2 h; maximum of 240 mg/24 h) begins in the recovery room and continues up to 72 h. The primary efficacy endpoint in this trial is patient global assessment (PGA) of pain control at 24 h. Secondary endpoints include pain control, safety, ease-of-use questions for patients, nurses, physical therapists for all surgery types, and technical failures. The statistical objective is an equivalent proportion of PCTS successes to IV PCA morphine by a 95% two-sided confidence interval for the difference between treatments at 24 h (± 10% to 10%).

Results and Discussions: The PGA as defined by the proportion of patients rating each method of pain control as poor, fair, good or excellent will be compared. Analysis of secondary endpoints will determine potential differences of administration between the two treatments in each patient population.

Conclusion(s): The findings of this study will demonstrate the efficacy and safety of fentanyl HCl PCTS vs IV PCA morphine in the management of postoperative pain in patients who have undergone major abdominal or orthopaedic surgery within 11 European countries.

Acknowledgement: Supported by Janssen-Cilag Ltd.

A-737
Interaction between bupivacaine and glutamate receptor antagonists in spinally mediated analgesia in rats
T. Nishiyama
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Background and Goal: N-methyl-D-aspartate (NMDA) receptor and α-amino-3-hydroxy-5-methylisoxazole-4-propionic acid (AMPA) receptor had a great role in pain mechanism in the spinal cord. We investigated the analgesic interaction between spinally administered bupivacaine and AP-5, a NMDA receptor antagonist; or YM872, an AMPA receptor antagonist using rats.

Materials and Methods: Sprague-Dawley rats with lumbar intrathecal catheters were tested for their thermal tail withdrawal response using the tail flick test and for their paw flinches by formalin injection after intrathecal administration of bupivacaine, AP-5, or YM872. The effects of the combination of bupivacaine and AP-5 or YM872 were tested by an isobolographic analysis using ED50 (50% effective dose) values. Eight rats were used in each dose group. Behavioral side effects were also investigated.

Results and Discussion: ED50 values are shown.

<table>
<thead>
<tr>
<th></th>
<th>Tail flick</th>
<th>Formalin phase 1</th>
<th>Formalin phase 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bupivacaine (μg)</td>
<td>7.0 (3.5–13.4)</td>
<td>5.6 (1.9–15.4)</td>
<td>3.3 (0.5–6.8)</td>
</tr>
<tr>
<td>AP-5 (μg)</td>
<td>5.0 (3.3–10.8)</td>
<td>7.5 (4.0–13.1)</td>
<td>15.0 (5.0–59.0)</td>
</tr>
<tr>
<td>YM872 (μg)</td>
<td>1.0 (0.4–2.8)</td>
<td>0.24 (0.08–0.75)</td>
<td>0.2 (0.07–0.7)</td>
</tr>
<tr>
<td>Bupivacaine + AP-5</td>
<td>2.96 (1.50–5.89)</td>
<td>0.89 (0.39–2.06)</td>
<td>0.89 (0.49–1.60)</td>
</tr>
<tr>
<td>AP-5 (μg)</td>
<td>2.44 (1.25–4.74)</td>
<td>0.37 (0.16–0.85)</td>
<td>0.37 (0.2–0.87)</td>
</tr>
<tr>
<td>YM872 (μg)</td>
<td>0.90 (0.62–1.31)</td>
<td>0.14 (0.02–1.04)</td>
<td>0.37 (0.03–5.04)</td>
</tr>
</tbody>
</table>

(1): 95% confidence interval.

Behavioral side effects decreased by both combinations compared with each single agent.

Conclusions: Intrathecal bupivacaine and AP-5 or YM872 were synergistically analgesic on thermal and inflammatory pain except for bupivacaine with AP-5 on thermal pain, which had additive effect.

A-738
Safety of high dose intrathecal diamorphine in non-obstetric patients
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Department of Anaesthesia, John Radcliffe Hospital, Oxford, United Kingdom

Background and Goals: The use of intrathecal diamorphine combined with bupivacaine has been shown to provide effective and prolonged postoperative analgesia following major orthopaedic surgery (1). It is suggested that
lipophilic opiates may be safer for intrathecal use because of their shorter life in the spinal fluid phase\(^2\). We have collected respiratory depression data from 661 patients receiving intrathecal diamorphine up to 1mg for non-obstetric surgery.

### Results and Discussions: Data are shown in the table.

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>%</th>
<th>NaLOXONE</th>
<th>RR</th>
<th>RR=80 yrs</th>
<th>RR SS 80 yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>ITD</td>
<td>1071</td>
<td>62</td>
<td>6</td>
<td>1.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ITD + PCA</td>
<td>661</td>
<td>38</td>
<td>3</td>
<td>0.81</td>
<td>0.35</td>
<td>2.29</td>
</tr>
<tr>
<td>ITD0.5 + PCA</td>
<td>233</td>
<td>13</td>
<td>1</td>
<td>0.77</td>
<td>0</td>
<td>2.45</td>
</tr>
<tr>
<td>ITD1.0 + PCA</td>
<td>298</td>
<td>17</td>
<td>2</td>
<td>1.20</td>
<td>0.72</td>
<td>3.64</td>
</tr>
</tbody>
</table>

*Denotes unavailable data.

### Conclusions:

The use of intrathecal diamorphine at doses up to 1mg in non-obstetric patients is a safe technique for patients under 80 years of age. Intrathecal diamorphine should be used cautiously in patients 80 years of age and over. Intrathecal diamorphine is no more likely to cause respiratory depression than PCA alone if used appropriately.

### References:


### A-739

**Local effect of bupivacaine and amitriptyline infiltration on wound NGF expression after plantar incision in rats**

P Lavand homme, V. Collet, M. De Cock

**Department of Anesthesiology, St Luc Hospital, Brussels, Belgium**

### Background:

Local NGF expression increases after plantar incision, contributing to peripheral sensitization and postoperative pain (1). While wound infiltration with bupivacaine (bupi) only provides shortlasting analgesia, we previously demonstrated that local amitriptyline (AMIT), a tricyclic antidepressant which acts as a long-lasting local anesthetic and possess antihyperalgesic effects, potentiates bupi and produces longlasting relief of post-incisional hyperalgesia (2). The present study evaluates whether bupi and/or AMIT effect might be related to modulation of local wound NGF expression.

### Materials and Methods:

Under halothane anesthesia, adult male Wistar rats underwent a plantar incision (1). Before wound closure, local infiltration (total volume 0.2 mL) was realized with either saline, bupi 0.5% alone or with AMIT 100 μg, or AMIT alone 100 μg (2). Animals (n = 3–4 per group) were killed at day (D)0 (6 h), D1 or D2 after surgery and plantar skin and muscle were harvested to measure tissue NGF (ELISA, Chemicon\(^\circ\)). NGF was also measured in normal tissue (Naive group). Statistical analysis used ANOVA and posthoc test, results are expressed as mean ± SD (ng/g tissue wet weight). Basal NGF in naive rats was 0.1 ± 0.01 ng/g. Plantar incision significantly increased local NGF secretion at D1 and D2 (Saline group data).

<table>
<thead>
<tr>
<th></th>
<th>D0 (N)</th>
<th>D1 (N)</th>
<th>D2 (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Saline</td>
<td>0.14 ± 0.05</td>
<td>0.21 ± 0.08*</td>
<td>0.3 ± 0.09*</td>
</tr>
<tr>
<td>Bupi</td>
<td>0.23 ± 0.1</td>
<td>0.04 ± 0.01</td>
<td>0.13 ± 0.04</td>
</tr>
<tr>
<td>Bupi AMIT</td>
<td>0.06 ± 0.02**</td>
<td>0.08 ± 0.03**</td>
<td>0.23 ± 0.05</td>
</tr>
<tr>
<td>AMIT</td>
<td>0.14 ± 0.11</td>
<td>0.06 ± 0.01*</td>
<td>0.4 ± 0.03*</td>
</tr>
</tbody>
</table>

*P < 0.01 with naive rats; **P < 0.01 with Saline group at the same postoperative time.

### Discussion and Conclusion:

As demonstrated in another model (3), bupi modulates NGF secretion. Temporary reduction of enhanced NGF expression correlates with bupi short-lasting postoperative analgesic effect. Low dose AMIT potentiates bupi effect on NGF expression that might contribute to and partly explain long-lasting postoperative effect of bupi AMIT combination.

### References:


### A-740

**Epidural analgesia: catheter contamination and secure time window**

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### Background and Goal of Study:

Epidural analgesia in surgical patients is not risk exempt. Epidural catheter (EC) tip colonization is up to 28.8% in some series \(^1\) and may be associated with significant clinical infection \(^2\). The aim of this study was to evaluate the relationship between microbiological EC contamination and the duration of catheterization in surgical patients.

### Materials and Methods:

Bacteriological analysis of 104 triple EC cultures was carried out after removal in surgical patients: exit site swabs (CS), semi-quantitative culture of 3 cm of intra-dermis portion (IC) and 3 cm of tip (TC). We recorded the duration of catheterization. Descriptive statistical analysis and Mantel-Haenszel Chi-Square tests were performed.

### Results and Discussions:

ECs were kept in place for 69 ± 34 hours (range 24–264). A significant correlation was found between the incidence of positive cultures and the duration of catheterization (CS \(p = 0.002\), IC \(p = 0.027\), TC \(p = 0.026\)). 64% of positive CS had also a positive IC and TC (decreasing number of colonies forming units from the skin to the tip). Coagulase-negative staphylococci (CNS) was the most prevalent micro-organism cultured.

### Conclusion:

Contamination of the exit site by normal skin flora and subsequent spreading along the catheter track seems to be the most likely route of ECs colonization. The longer the catheterization, the higher the risk of ECs contamination gets. In surgical patients, ECs have to be removed when no longer needed for pain relief.

### References:


### A-742

**Safety and innovation: a unique method to manage postoperative pain**

D. Jones, U. Richarz

**Clinical Development, ALZA Corporation, Mountain View, USA**

### Background and Goal of Study:

The noninvasive, iontophoretic, fentanyl HCl patient-controlled transdermal system (PCTS) is therapeutically equivalent to a standard regimen of IV PCA morphine for the treatment of postoperative pain. The PCTS does not require bulky equipment and its preprogrammed nature eliminates the risk of medication errors due to improper programming observed with infusion pumps \(1\). This analysis assessed the safety of the PCTS in 3 phase III clinical trials.

### Materials and Methods:

An integrated analysis of safety data from 3 randomized controlled trials (n = 1325) was conducted. The PCTS (n = 714; 40-μg fentanyl over 10 min; up to 6 doses/h) was compared with transdermal placebo (n = 291) or a standard regimen of IV PCA morphine (n = 320; 1-mg bolus, 5-min lockout interval; up to 10 doses/h). Patients were titrated to comfort using IV opioids prior to treatment. Respiratory function was the primary safety measure. Adverse events (AEs) and application site reactions were also assessed. Patients who had at least 1 PCTS applied or IV PCA device enabled were included. Safety data from the initiation of treatment through 24 hours after the last dose were summarized.

### Results and Discussions:

Frequently reported AEs in PCTS vs placebo and IV PCA vs IV PCA morphine studies were: nausea (37.9%; 21.2% and 44.0%; 49.1%), fever (8.6%;10.4% and 20.9%; 20.3%), headache (8.6%; 6.6% and 14.9%; 9.1%), and vomiting (11.8%; 5.7% and 11.1%; 9.4%), respectively. Respiratory AEs were uncommon with the PCTS and IV PCA morphine studies: hypoxia 4.1% and 3.4% and pharyngitis 2.5% and 1.6%, respectively. Clinical relevant respiratory depression (CRRD) was not observed with the PCTS; however, 1 case was reported with IV PCA morphine. Mild application site erythema was reported with the PCTS (14.1% vs placebo and 2.2% vs IV PCA), whereas pruritus occurred predominately with IV PCA morphine (12.5%).
Conclusion(s): The PCTS is well tolerated and the incidence of opioid-related AEs was similar to that observed with IV PCA morphine.


Acknowledgement: Supported by ALZA Corporation.

A-743
Total knee arthroplasty relieves sexual dysfunction due to chronic painful knee disease
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Department of Anesthesia and Intensive Care, University Hospital, Vienna, Austria

Background and Goal of Study: Sex is an important contributor to quality of life and people are staying sexually more active even during older age, given motility is not impaired. Total knee arthroplasty (TKA) is a widely accepted surgical procedure relieving pain and improving function. Although the increase in quality of life is well documented, the effect of knee disease and total knee arthroplasty on sexual function have not been surveyed yet.

Materials and Methods: We investigated 171 patients (>19 years) having got TKA within the last 2 years and at least within the last 6 months. Those living in an active sexual relationship were asked to an interview, either personal or on the phone, about the kind and duration of their knee disease, sexual problems due to this, function, pain and sexuality after total knee arthroplasty.

Results and Discussions: From 109 patients we could reach, 48 (21 male, 57 ± 12 years, 27 female, 59 ± 8 years) had sexual partners and were willing and/or able to participate. No inference with knee impairment was seen in 48%, from the 52% (n = 25) with impaired sexual function, in 60% (n = 15) sexual function improved after operation, 8% (n = 2) had only slightly improvement, where 32% (n = 8) had no increase in sexual activity. Main reason (94%) was seen in better function of the knee. Interestingly, the preferred position during sex has not been influenced.

Conclusion(s): Our data show that knee disease often impairs sexual function. Total knee arthroplasty is an appropriate procedure to improve sexual activity and probably quality of life in these patients.

A-744
Pupil dilation response to noxious stimulation during midazolam sedation
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Background and Goal: The pupil dilation response (PDR) to a painful stimulus is a subtle, event-related increase in pupil diameter that occurs following brief noxious stimulation. It varies in amplitude with increasing stimulus intensity. However, diameter of pupil changes by mental activities such as excitement or fear. We made a hypothesis that PDR could be an objective parameter for sedation level, to determine: 1) whether decreases in PDR amplitude to midazolam sedation could be demonstrated; and 2) whether such change would be parallel alterations in BIS.

Materials and Methods: In a double blind trial, twelve healthy, female volunteers ranging in age from 25 to 28 years as subjects participated in this study. Subjects repeatedly experienced a painful electrical stimuli (VAS = 8, ISI = 9–11 sec) delivered to a fingertip to measure PDR, Somatosensory Evoked Potentials (SEP). Sedation was induced with a bolus intravenous administration of midazolam (0.075mg/kg) to compare PDR, SEP and BIS value before and after the sedation.

Results and Discussions: A PDR for a typical subject is shown in the figure:

Conclusion(s): 1) Amplitude of PDR decreased with midazolam sedation; 2) Amplitude of PDR correlated consistently with BIS. PDR amplitude appears to be a useful approach for the assessment of sedation level.


Acknowledgement: Sato Fund of Nihon University School of Dentistry (2004) supported this work.

A-745
Preanaesthetic information: do patients benefit?
Department of Anesthesiology, Hospital Mar-Esperanza. IMAS, Barcelona, Spain

Background and Goal of Study: To evaluate the benefits and approval of the information given and that anaesthesia (IC) by our patients.

Materials and Methods: An opinion questionnaire was designed together with the Epidemiology Department of our hospital consisting of: (A) Demographic data (age, gender, education level: illiterate, primary school, secondary school and university). (B) Benefits of the IC: 1. To get the right amount of support from others in making the choice; 2. To make the choice without any pressure from others; 3. To have enough advice about the options. (C) Disadvantages: 1. Increasing doubts about the operation; 2. Increasing fear of surgical operation. (D) Approval of signing the IC. Population questioned: Spanish speakers, between 18–85 years old, scheduled to undergo an operation. Cut off age: 55 years old. Standard of evaluation: age, gender and education level. The evaluation scale of the answers was: agree, disagree, neither agree nor disagree. All patients had previously received oral and written information about the anaesthetic process. Statistic significance: p < 0.05.

Results and Discussions: A total of 318 questionnaires were given out and 301 (94.6%) were completed. Average age: 52.4 (16.24), 57.5% were women, 52.3% had low studies. It is noteworthy that 2.7% were illiterate people. Patients under 55 years old were educated people (p = 0.001). In relation to the benefits of the information given, patients over 55 years old with basic studies had the right amount of support in making their choice (p = 0.01) without any pressure from others (p = 0.02), but their fear of the operation increased (p = 0.01). Patients under 55 years old had increased doubts about the operation (p = 0.009). Women showed a high interest in the operation process, but their fear increased (p = 0.001). 74.9% of the patients considered it necessary to sign the IC (no statistical differences among variables).

Conclusion: Preanaesthetic information given to patients should be adapted to their age, gender and education level. Young educated patients are more knowledgeable and demand more in-depth information, but that increases their doubts about the operation. We should emphasize the value of the preoperative visit and the importance of good communication skills.

A-746
Preemptive epidural analgesia with bupivacaine and the effects of epidurally added epinephrine for thoracic surgery
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Clinical Center, Clinic of Anaesthesia, Reanimation and Intensive Care, Skopje, Macedonia

Background and Goal of Study: To determine if preemptive epidural analgesia performed before thoracotomy incision and during the operation reduces postoperative pain, and to compare these effects according to the usage of epinephrine.

Materials and Methods: Sixty patients admitted for thoracic surgery were randomly allocated into three groups (n = 20 each). Group A received 9 ml 0.25% of bupivacaine and 1 ml of sufenta forte (50 µg/ml) via the epidural route prior to skin incision, followed by an infusion of bupivacaine 0,125% and sufenta forte 2 µg/ml at 6 ml/hr. Group B (control) received saline in the epidural. In both groups patients received 9 ml of bupivacaine 0,25% and 1 ml of sufenta forte (50 µg/ml) via the epidural route at the time of the chest closure. In the third group (group C), the same doses of bupivacaine and sufenta forte, identically as in group A, were given to the patients including epinephrine in the epidural mixture (1:200000). The level of statistical significance was pointed at p < 0.05.

Results and Discussions: The patients in the group A had lower maximum pain scores in the first 8 hours postoperatively, with less isofluran
requirements intraoperatively and better pulmonary functions, compared with the control. In the epinephrine group patients had lower pain intensity (for 2–3 scores at VAS) and smaller clinical needs for the rate of the epidural infusion postoperatively than those in the group A. The usage of epinephrine has caused less nausea and easier mobilization.

**Conclusion(s):** While there was a beneficial effect of the reduced intraoperative anesthetic requirements, any lasting effect of preemptive ansthesia did not extend beyond 8 hours after the operation. Epinephrine, however, has a marked role in pain relief when added to the local anesthetics and opioids for the epidural analgesia in thoracic surgery.

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**A-747**

**Comparison of the postoperative analgesic effect produced by epidural infusion of ropivacaine and fentanyl with and without adrenaline**

P. Javellas, P. Babali, M. Papaioannou, A. Katsioulas, A. Palgimesi

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**Background and Goal of Study:** Basic pharmacological research indicates that there is positive pharmacodynamic interaction between adrenaline, ropivacaine and fentanyl during epidural analgesia (1). The objectives of the present study were to evaluate whether adrenaline added to epidural ropivacaine-fentanyl infusion improved pain relief and decreased the incidence of adverse effects (2).

**Materials and Methods:** A prospective, randomized study was carried out in 28 patients after major orthopedic surgery. Patients were given continuous epidural ropivacaine 2 mg/ml–fentanyl 0.25 μg/ml infusion either with (n = 16) or without (n = 12) adrenaline (2 μg/ml) for postoperative pain relief and observed for three days. Intravenous tropisetron and intramuscular ketoprofen were administered to all patients. Main outcome measures were pain intensity at rest and during activity, evaluated on a 0–10 pain scale where 0 = no pain and 10 = worst possible pain, drug consumption, incidence and severity of adverse effects (i.e. nausea, vomiting, pruritus, drowsiness, respiratory depression, hemodynamic instability, urinary retention, motor blockade). All the data were analyzed using the SPSS for Windows version 10.5 computer program.

**Results and Discussions:** There were no significant differences between the two study groups with respect to age, sex, ASA-group or surgery performed. The need for ropivacaine (P = 0.001) and fentanyl (P = 0.001) as well as observed pain scores were significantly lower in the triple epidural mixture group than in the double epidural mixture group. Pain intensity differences at rest were less pronounced. The incidence of nausea, vomiting and pruritus was lower in the triple epidural mixture group (P = 0.028). Other adverse effects were not noted in either study groups.

**Conclusion(s):** Adrenaline (2 μg/ml) improves the pain-relieving effect, facilitates mobilization and decreases the occurrence of adverse effects when added to an epidural infusion of ropivacaine 2 mg/ml and fentanyl 2.5 μg/ml after major orthopedic surgery.

**References:**


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**A-748**

**Levobupivacaine for postthoracotomy pain: is epidural catheter more successful than extrapleural intercostal nerve block analgesia?**

A. Clemente, A. Cardone, R. Caserta, P. Aceto, E. Congedo, G. De Cosmo

Department of Anaesthesiology and Intensive Care, Catholic University of Sacred Heart, Rome, Italy

**Background and Goal of Study:** Leobupivacaine, the pure S-enantiomer of racemic bupivacaine, retains similar local anesthetic properties and efficacy to racemic bupivacaine, but has been shown to have less cardiotoxic potential. We compare its use in two analgesic techniques for postthoracotomy pain.

**Materials and Methods:** 30 patients undergoing elective lobectomy were randomized to each group. Patients in epidural group (EPI group) received a continuous infusion (5 ml/h for two days) of levobupivacaine 0,125% plus sufentanil 1 mcg/ml through a thoracic epidural catheter inserted preoperatively. Patients assigned to extrapleural group (EXT group), just before chest closure, a catheter was placed extrapleurally in a dorsal paravertebral position perpendicular to 3 to 4 intercostal spaces and, after a bolus of 20 ml of levobupivacaine 0,5%, a continuous infusion of levobupivacaine 0,25% at 5 ml/h for two days was started. Each patient had a Patient Controlled Analgesia device programmed to deliver a bolus of morphine 0,6 mg with a lockout of 7 min. Resting and dynamic visual analog pain scale, respectively VASr and VASi (range from 0 to 10) were measured basally, at the end of surgery then hourly up to 4 h and then each 4 h until 48 h. Total morphine consumption was registered.

**Results and Discussions:** In both groups an effective control of postoperative pain was obtained (always VASr < 4 and VASI < 5). VASr values were lower in EPI group during the first 24 h and mean consumption of morphine was greater in EXT group during the two postoperative day, but these differences were not statistically significant. Two patients of EXT group experienced vomiting and one required a supplemental analgesic (ketorolac 30 mg).

**Conclusion(s):** The slightly better quality of analgesia in EPI group cannot justify exposing patient to serious complications, albeit rare, of epidural catheter. Extrapleural intercostal analgesia might be a valuable alternative (1), particularly for patients who either do not qualify for epidural analgesia or refuse it.

**Reference:**


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**A-749**

**Effect of pediatric cardiopulmonary resuscitation course on pediatric resident knowledge**

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**Background and Goals:** Guidelines for resuscitation training have been written in both Australia and the United Kingdom, and an advanced life support group has been formed with the aim of improving the emergency care of patients. 1,2 We tried to evaluate pediatric residents’ knowledge in cardiopulmonary resuscitation before and after Pediatric Advanced Cardiac Life Support course.

**Material and Methods:** After an examination from all pediatric residents of Tehran University of Medical Sciences we divided participants into two groups, non trained group (group 1) and group that had to undergo training (group 2). We scheduled the course for group 2, and a month later, a reexamination from the previous topic was taken from all participants.

**Results:** The mean of the first examination score in group 1 and group 2 was low and reflecting no significant differences between the groups. In the reexamination after the Pediatric Advanced Cardiac Life Support course for half of the volunteers, the results showed a statistically significant improvement in group 2 (P < 0.05). Data (Mean ± SD and P value) are shown in the Table 1:

<table>
<thead>
<tr>
<th></th>
<th>Group 1</th>
<th>Group 2</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean ± SD of A1</td>
<td>5.27 ± 1.24</td>
<td>5.41 ± 1.73</td>
<td>0.766</td>
</tr>
<tr>
<td>Mean ± SD of A2</td>
<td>4.5 ± 1.65</td>
<td>7.45 ± 0.91</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Mean ± SD of D1</td>
<td>4.27 ± 1.12</td>
<td>4 ± 1.48</td>
<td>0.495</td>
</tr>
<tr>
<td>Mean ± SD of V2</td>
<td>4.05 ± 1.74</td>
<td>7.05 ± 1.17</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Mean ± SD of D1</td>
<td>3.55 ± 1.1</td>
<td>4.1 ± 0.73</td>
<td>0.154</td>
</tr>
<tr>
<td>Mean ± SD of D2</td>
<td>4.68 ± 1.17</td>
<td>6.2 ± 1.23</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Mean ± SD of total score in first exam</td>
<td>13.23 ± 2.75</td>
<td>13.64 ± 2.75</td>
<td>0.418</td>
</tr>
<tr>
<td>Mean ± SD of total score in second exam</td>
<td>13.23 ± 2.75</td>
<td>20.45 ± 2.2</td>
<td>&lt;0.0001</td>
</tr>
</tbody>
</table>

A1: Air way management score in first exam; A2: Air way management score in second exam; V1: vascular access score in first exam; V2: vascular access score in second exam; D1: Drug information score in first exam; D2: Drug information score in second exam.
A-750
Resuscitation of the newborn – a workshop for anaesthetists
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Background and Goal of Study: Anaesthetists have the skills to appropriately resuscitate asphyxiated newborns, but if these skills are used infrequently and in an unfamiliar context, performance may suffer. This workshop, conducted at the Australian Society of Anaesthetists ASM 2004, aimed to review the pathophysiology of neonatal asphyxia, increase familiarity with equipment for newborn resuscitation and to enhance teamwork, communication and performance skills.

Materials and Methods: A didactic presentation was followed by familiarisation with the resuscitation equipment and simulation manikins. Laerdal ALS baby manikins were modified to simulate spontaneous ventilation and to have a palpable umbilical pulse. Both parameters could be varied by the instructor without the candidate’s knowledge forcing them to examine and re-examine the manikins as scenarios evolved. Small groups, each with their own instructor, had to work as a team in 3 resuscitation scenarios.

Results and Discussions: Thirty two questionnaires were completed by 27 consultant anaesthetists, two trainees, two general practitioners and one clinical nurse consultant. Thirteen of the 32 had resuscitated a baby in the previous year. Only 8 felt confident of their abilities before the workshop. After the workshop, only one was still not confident. All 32 felt that their skills had improved and would recommend the workshop to their peers. Thirty one thought that they would like to do the workshop again.

Conclusion(s): This workshop using interactive techniques and an augmented manikin was well received and proved effective in improving confidence in newborn resuscitation.

A-751
Undergraduate medical students attitudes toward pain – comparison between the first and the last year students
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Background: The current education in the assessment and management of pain does not provide doctors with the skills needed in the clinical practice (1,2). In our faculty, pain-related topics are taught throughout the study time, but there is no specific written pain curriculum (3). There is a brief intensive course on pain during the 6th study year. The purpose of this study was to compare the first and the last year medical students’ attitudes about pain.

Methods: A questionnaire was constructed using attitudes and knowledge described in previous studies (1,3) as well as attitudes concerning use of opioids for both chronic and cancer pain. Each item (24) was asked using three different formulations and there was 70 items in the questionnaire (Likert scale 1–7). The students were asked to provide their names. The questionnaire was given to the 6th year students before a brief intensive course on pain. The 1st year students served as a control group. Re-test was made electrically to the 1st year students 2 weeks after the first questionnaire and to the 6th year students one month after the intensive course.

Results and Discussion: Eighty-four 1st year students out of 110 (76.3%) and 78/97 of the 6th year students (80.4%) answered the questionnaire. Internal consistency was acceptable in six of the 24 items (Cronbach alpha >0.6). The re-test from the 1st year students showed good correlation (Spearman Rank, correlation coefficient-efficient mean 0.74). The 6th year students re-test correlated with the pre-course results (Spearman Rank, correlation coefficient mean 0.76). The 6th year students had strict opinions about pain, while the 1st year students were more neutral with their views. The 6th year students were more concerned about meeting patients with chronic pain (4.63 SD 1.35 vs. 3.67 SD 1.31). The 1st year students were more concerned about risk for opioid addiction in cancer patients (4.11 SD 1.47 vs. 1.22 SD 0.45).

Conclusion: We concluded that knowledge of pediatric residents in all the subtitles of cardiopulmonary resuscitation was low, and after pediatric Advanced Cardiac Life Support course, their knowledge enhanced.

References:

A-752
Generating a learning curve for the Bonfils Intubation Fiberscope. A pilot study evaluating the difference between novice and staff anaesthetists
S. Augustin, G. Schuepfer, N. Kafft, T. Heidegger, H. Gerg
Department of Anaesthesiology, Kantonsspital St. Gallen, St. Gallen, Switzerland

Background and Goal of Study: The rigid Bonfils Intubation Fiberscope (BIF) used by experienced anaesthetists is an effective instrument for orotracheal intubation (1) and a suitable alternative for management of the unanticipated difficult airway (2). The goal of this study was to find any difference between residents and staff anaesthetists when performing orotracheal intubation using a BIF by generating a learning curve and to define a minimal case load necessary to master this technique.

Materials and Methods: After ethics committee approval four novice anaesthetists (R) and three staff anaesthetists (S) performed 40 intubations with a BIF in elective surgical patients. All participants were naive for this method. Exclusion criterions were ASA >II, Arne-score for preoperative assessment for difficult intubation >11, and age <18 years. Anaesthesia was induced with Fentanyl 1,5 µg/kg, Propofol 2 mg/kg, and Rocuronium 0,6 mg/kg. Intubation was attempted after 120 sec. Successful intubation was defined as duration of the procedure <80 sec, and less than three attempts.

Results and Discussions:

<p>| Table. Learning Bonfils Laryngoscopical Intubation. |</p>
<table>
<thead>
<tr>
<th>N</th>
<th>CI lower 95%</th>
<th>MEAN</th>
<th>CI upper 95%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Success rate after 20 attempts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R</td>
<td>S</td>
<td>7</td>
<td>0.708</td>
</tr>
<tr>
<td>S</td>
<td>3</td>
<td>0.715</td>
<td>0.8333</td>
</tr>
<tr>
<td>R</td>
<td>4</td>
<td>0.6406</td>
<td>0.75</td>
</tr>
<tr>
<td>Success rate after 40 attempts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R</td>
<td>S</td>
<td>7</td>
<td>0.77</td>
</tr>
<tr>
<td>S</td>
<td>3</td>
<td>0.81</td>
<td>0.88</td>
</tr>
<tr>
<td>R</td>
<td>4</td>
<td>0.68</td>
<td>0.75</td>
</tr>
</tbody>
</table>

*P 0.002 (N: number; CI: confidence interval).

Conclusion(s): Staff anaesthetists had a statistically significant better overall success rate than residents and learned faster. The overall success rate after 40 attempts was 81.7% for both groups. Our findings suggest that a higher case load (>40 attempts) may be necessary to master this intubation method with a high success rate (>95%).

References:

A-753
Success rate of intubating with the Bonfils Intubation Fiberscope. A pilot study to evaluate the difference between novice and staff anaesthetists
S. Augustin, G. Schuepfer, N. Kafft, T. Heidegger, H. Gerg
Department of Anaesthesiology, Kantonsspital St. Gallen, St. Gallen, Switzerland

Background and Goal of Study: The Cumulative Sum Method (CUSUM) is recommended as a statistical method for measuring individual performance (1,2). Therefore, learning of endotracheal intubation with a Bonfils Intubation Fiberscope (BIF) was studied using this technique. It is possible with this technique to visualise learning progress.

Materials and Methods: After ethics committee approval four residents and three staff anaesthetists were included to perform 40 intubations with a BIF. All persons involved in the study were naive for the BIF intubation technique. Exclusion criteria were ASA >II, Arne-score for preoperative assessment for difficult intubation >11, and age <18 years. Anaesthesia was induced with Fentanyl 1,5 µg/kg, Propofol 2 mg/kg, and Rocuronium 0,6 mg/kg. Intubation was carried out after 120 sec. Successful intubation
was defined as duration of the procedure ≤ 80 sec, and less than three attempts. The following assumption were made for the calculation of the CUSUM value: acceptable failure = 0.05 and unacceptable failure 0.1 (alpha 0.05; beta = 0.1).

Results and Discussions: CUSUM plots for all trainees are shown in the graph. Overall success rate of residents an staff was 81.7% (95% confidence interval 0.77-0.86).

Conclusion(s): Using the CUSUM technique a conclusive number for definition of the minimal case load for BIF was not possible within 40 attempts. Therefore alternative methods for the generation of valid learning curves must be considered.

References:

A-754
The European Diploma in anaesthesiology and intensive care, and the in training assessment as tools of training evaluation: ten years of experience
A. Mases, S. Bermejo, J. Valles, E. Samso, F. Escolano
Department of Anaesthesiology, Hospital del Mar, Barcelona, Spain

Background and Goal of Study: Exams are recognized tools for assessing theoretical knowledge acquisition and can also be used as a training program evaluation. The European Diploma of Anaesthesia (EDA) was introduced in 1984 as a comprehensive test of knowledge of anaesthesia, critical care and pain management and it has become an international European standard. Our objective was to determine if there is a pattern of knowledge acquisition related with the year of training and also we wanted to compare our results with the European average.

Materials and Methods: From 1994 to 2004, 29 residents (8 second year (R2), 21 third year (R3)) presented to the in training assessment of EDA exam. Also, 18 candidates presented to the EDA part I. We compared the detailed results among the different stage of training. Scores of European and our department EDA candidates were graphically compared.

Results and Discussions: There is a lack of progression in knowledge acquisition between R2 and R3 and the bulk of knowledge was obtained just before the EDA part I. When the scores of the European and our EDA candidates were graphically plotted, similar detailed results are observed.

Conclusions: a) the greatest part of the knowledge is reached during the last year of training, b) our department EDA candidates reach the mean European level of theoretical concepts, c) the EDA part I and the In Training exams are helpful tools for the evaluation of knowledge progression.

A-755
Simulator-based training increases students self-perceived anaesthesia competencies
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Background and Goal: Simulator-based training for medical students has been introduced into the curriculum to teach basic anaesthesia skills. The goal of our study was to evaluate this teaching-program.

Materials and Methods: 177 students participated in two one-hour simulation sessions introducing them to basic anaesthesia skills using a full-scale human patient simulator. To evaluate the training, two outcome criteria were used (1). First, students’ reactions to the training were assessed by questionnaire items concerning the simulator training’s perceived value. Second, student learning was assessed by collecting questionnaire data on students’ self-perceived anaesthesiology competencies (concerning diagnosis, airway management, drug knowledge and administration, and communication competencies). Students rated their level of agreement with the items on a 6-point Likert scale (from 1 = strong agreement/high competency, to 6 = strong disagreement/low competency).

Results and Discussions: The reaction data showed that the participants considered the training relevant (M = 1.55; SD = 0.80), the simulator to be an appropriate learning tool (M = 1.65; SD = 0.80) and that they were overall satisfied with the training (M = 1.76; SD = 0.93). For the learning data, the conducted repeated measurements MANOVA yielded a significant overall effect for time of measurement (p < .001), indicating that the training led to an increase in students’ self-perceived anaesthesia competencies. Univariate results are reported in the table.

<table>
<thead>
<tr>
<th>Competency scale</th>
<th>Pre M/SD</th>
<th>Post M/SD</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis</td>
<td>3.83/85</td>
<td>3.49/82</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Airway management</td>
<td>4.23/1.00</td>
<td>2.91/86</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Drug knowledge/administration</td>
<td>4.78/95</td>
<td>3.50/1.03</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Communication</td>
<td>3.40/84</td>
<td>2.85/81</td>
<td>&lt;.01</td>
</tr>
</tbody>
</table>

Control group data and more objective measures should be collected in the future.

Conclusion: Students consider simulator training as appropriate and their basic anaesthesia competencies increase.


A-758
Comparison of the stress induced by simulation-based training to stress during actual induction of anesthesia in the operating room
Y. Yusim, A. Perel, A. Tuval, A. Ziv, H. Berkenstadt
Department of Anaesthesiology and Intensive Care, Sheba Medical Center, Tel Aviv University, Ramat Gan, Israel

Background and Goal of Study: Full-scale medical simulation is used for training and evaluation of anaesthesiologists. The realistic properties of simulation-based training are commonly assessed by subjective questionnaire filled in by the trainee. The development of more objective parameters may improve the evaluation of simulation-based training. The aim of the present study was to compare the stress response, as reflected by the heart rate (HR) and by subjective questionnaire, during simulation-based training, and during the actual induction of anesthesia in the operating room (OR).

Materials and Methods: The HR of 14 junior anaesthesia residents was measured continuously during 2 hours of a simulation-based training that included 5 scenarios (esophageal intubation, bronchospasm, malignant hyperthermia, anaphylaxis and pediatric resuscitation). Questionnaires for stress levels were filled by the participants before training, between the
A-759
The PDA: a powerful and portable teaching tool
E. Leon-ruiz
Department of Anesthesiology, University Hospitals of Cleveland, Cleveland, USA

Background and Goal of Study: Teaching endotracheal intubation (EI), central venous access (CVAC), regional blocks (RB) and echocardiography (E) demands visual didactic aids (books, “dummies”, electronic video display tools) that are difficult to take to the operating theaters. A personal digital assistant (PDA) is an easily portable device that can store data, images and videos. A successful study was done to convert the PDA into a didactic tool.

Materials and Methods: The materials used were a Palm Pilot 515 (PDA), an IBM compatible PC, a video capture card (VCC), a VCR player, an image editor (IE), and an image and video converter.

A set of pictures related to EI, CVAC, and RB were stored in the PDA. The pictures were either downloaded from the Internet, or scanned, or produced personally by digital photography. The pictures were formatted with an IE program to obtain images of adequate size (160 × 160 pixels) and color depth (256 colors) clear to read in the PDA screen. JASC Paint Shop Pro and Microsoft Paint make this process easy and fast. Firepad Picture Viewer (FPV) converted the images to .pdb files and displayed them in the PDA screen. E files were stored and displayed using also FPV. A VCC (All-in-Wonder 128 PRO) and a VCR made it possible to save echocardiographic video tapes as .avi files. Video for Windows, a simple but very effective video editor, was used to crop and resize the .avi files. The FPV converted the .avi to .pdb files quite easily. The same program displayed the videos in the PDA screen with accuracy.

Results and Discussions: The production, storage and display of the didactic material needed for teaching EI, CVAC, RB and E were possible with the tools described above. The funds and time invested were modest and the level of computer expertise was easy to achieve. The ability to illustrate with pictures the procedures at hand facilitated teaching and learning.

Conclusion: An easy to achieve level of computer expertise and a modest monetary investment can provide anaesthesiologists with a PDA programmed to enrich their teaching experience.

Reference:
1 Leon-ruiz E: PDAs as Echocardiography TAs. Anesth Analg 2002; 93, SCA 1.

A-760
Dresdner integrated problem-based learning: DIPOL®
course emergency medicine – injuries – intensive care medicine. Anaesthesiology as part of interdisciplinary undergraduate education
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Background and Goal of Study: As of October 1st 2003 a new government initiated legislative basis for undergraduate medical education in Germany was passed. This resulted in substantial changes in the structure of the medical curriculum and in heightened teaching load in particular. These changes have to be implemented in each German faculty’s undergraduate program.

Materials and Methods: The Carl Gustav Carus Faculty of Medicine of the Technical University Dresden already started to establish an interdisciplinary reform curriculum in 1998. Since then a hybrid model of traditional lectures, seminars, practical and problem based learning courses has been implemented for all courses in undergraduate medical training (Dresdner Integrated Problem-based Learning: DIPOL®).

Results and Discussions: The course concept and evaluation results of the 2003 “Emergency Medicine – Injuries – Intensive Care Medicine” course are presented. The results show that the course was very well received by students and tutors. 95% of the students passed the theoretical and practical exams.

Conclusions: Next to a description of the Dresden DIPOL® concept we report a course covering Anaesthesiology and Intensive Care Medicine that conforms with the new German federal law. The evaluation results demonstrate that students and tutors accept the new curriculum. A continuous further evaluation is an essential part of quality control and is necessary for the further development of a new curriculum.

A-762
Training and education tool for muscle relaxant administration regimes
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Background and Goal of Study: Development of a package to be used as an advanced tool for education and training purposes of drug administration regimes.

Materials and Methods: The package has been developed in MATLAB language, using the current features on graphic user interfaces, and may be used as an advanced simulation tool for the test and comparison of fairly different trial situations, under a variety of circumstances and muscle relaxant drugs, namely atracurium, cisatracurium, rocuronium and vecuronium. The software incorporates randomly generation of pharmacokinetic/pharmacodynamic models driven by simulated drugs administration regimes (bolus and/or continuous infusion). The package also incorporates several control strategies1 and it can be also used for the automatic control on patients undergoing surgery2. In order to provide a wide broad of situations, the friendly user interface and the toolbar enables/disables a variety of different options namely those related with operating mode, reference level, control strategies and the filtering methods.

Results and Discussions: The figure illustrates a graphical environment of a simulated case under manual control strategy.

Conclusion(s): The special features of this package give to the clinical staff a powerful tool, providing a variety of test situations namely a good insight on drug models and control strategies.

References:
2 EMSEC02, Vienna, Austria, 664–665.
Acknowledgement: Portuguese Foundation for Science and Technology.
A-763
Immediate reactions following contrast media injection: results of a 3-year multicenter survey
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Service Danesthésie-Réanimation Chirurgicale, CHU Nancy, Nancy, France

Background and Goal of Study: The aim of this 3-year (2001–2003) prospective multicenter study was to classify immediate reactions to iodinated contrast media (ICM) by using clinical data and skin tests.

Material and Methods: The following data were collected: name of injected ICM, gender, age of patients, time delay between injection and reaction, clinical signs classified according to the Ring and Messmer severity scale, treatment of the reaction, pretreatment before injection. Reactions were considered as IgE-mediated allergic hypersensitivity (anaphylaxis) where suggestive clinical symptoms and positive intradermal tests (IDT) with the culprit ICM were observed (Group I) or non-allergic hypersensitivity reactions where clinical signs were suggestive, but IDTs were negative (Group II).

Results and Discussion: 26 patients were classified, 19 patients (73.1%) entered Group I, non-ionic ICM were involved for 79% of them. Seven patients entered Group II (26.9%), all had received non-ionic ICM. In both groups, a female predominance was observed. The mean age was similar in both groups. The reactions occurred less than 5 minutes after injection in 75% of the cases in Group I and in 66.8% in Group II. Cutaneous signs were present in 95% of the patients of Group I and in all the patients of Group II, whereas cardiovascular signs (52.6%) and life-threatening reactions (36.8%) were seen only in Group I. Intravenous sympathomimetic drugs were injected for treatment in 29.4% of patients in Group I, but not in Group II. Corticosteroids and/or anti-H1 were administered to 70.6% of patients of Group I and to 58% of Group II. Reactions occurred despite pre-treatment in 50% of patients of Group I. Our results indicate that allergic hypersensitivity is the most frequent and clinically severe mechanism involved in immediate reactions to ICM and occur despite pre-treatment. Reactions are more numerous with non-ionic ICM reflecting probably the actual market use.

Conclusion: According to our results, anaphylaxis appears frequently responsible for immediate reactions following ICM injection. Patients who develop an immediate reaction following ICM injection should undergo allergological assessment. If the injected ICM gives a positive IDT, it should be definitively discarded.


A-764
Preferred head position in Great Britain during rapid sequence induction of general anesthesia for patients with increased risk for aspiration: an e-mail survey
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Background and Goal of Study: There has been hardly a consistent recommendation regarding the optimal head position during induction of general anesthesia in an effort to reduce aspiration risk. Among the scanty literatures two positions are recommended for different reasons: head-up and head-down. Proponents of the former argue that head-up position reduces aspiration risk from passive regurgitation by facilitating the gravitational force working in favor of the stomach. Proponents for the head-down position, on the other hand, point out that the risk is reduced, if and when active vomiting occurs, by draining the vomitus away from the trachea and out of the mouth for evacuation. Dr. Sellick who invented the famous Sellick Maneuver had recommended this position in his original paper (1). An E-mail question survey was sent out to 360 anesthesiologists in Great Britain to determine the preferred head position during rapid sequence induction for patients with increased aspiration risk.

Materials and Methods: The one-question survey elicited the respondents to choose one of the three possible positions: head-up, flat, or head-down. We did not select those who are with non-M.D. degrees or in residency training.

Results and Discussions: Among 154 responses (43% response rate), 132 (86%) indicated that they keep the patients’ head position flat; 16 (10%) indicated they raise the head up, 4 (3%) indicated they keep the head down and the remaining 2 (1%) were unclear. There was an overwhelming preference of the head position to be flat during rapid sequence induction for patients with increased aspiration risk. A similar result was obtained in a previous study in the US (2). It is interesting to note that no current major US textbooks in anesthesiology explicitly recommend flat head position as the optimal position to reduce the risk for aspiration.

Conclusion(s): The majority of anesthesiologists in Great Britain does not raise or lower the heads in relation to the patients’ feet when they perform rapid sequence induction. Patient’s head position does not seem to be a major factor in an effort to reduce the risk of aspiration during induction of general anesthesia.


A-765
Survey among Spanish anesthesiologists to evaluate the use of temperature monitoring and the application of methods to prevent hypothermia
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Background and Goal of Study: Non therapeutic intraoperative hypothermia has been related to a high incidence of complications (cardiovascular morbidity, coagulation impairment and postoperative infections)1–3. We performed a survey among Spanish anesthesiologists to evaluate the use of temperature (T) monitoring and the application of methods to prevent hypothermia in the operating theatre.

Materials and Methods: A survey was carried out in 70 hospitals of different characteristics (public, teaching and private) around Spain. A thousand questionnaires were distributed and 623 were completed. There were six main topics: A) Frequency of T monitoring, B) Professional who decided to monitor T, C) Surgical/patient criteria for monitoring T, D) Location of T monitoring, E) Method of prevention used in the operating theatre, if any, F) Attitude towards warming transfusion blood.

Results and Discussions: A) T was not monitored in any case by 43.5% of anesthesiasts (75% of them stated they no had means of performing it), 43.5% of anesthesiasts performed it in less than 50% of procedures and 9.6% assured that they monitor T in over 50% of patients. B) Decision to monitor T was taken in 87.6% of cases by the anesthetist, in 4.1% by surgeon, 1.3% by perfusionist and 1.1% by nurse. C) Criteria for T monitoring (multiple choice): 75% was length of surgery (51% >3hrs, 49% >2hrs), 26.4% patient’s age, 12.7% potential blood loss, 8.7% suspicion of malignant hypothermia. D) Location of T monitoring: pharyngeal or esophagus 56.7%, bladder 13.6% and rectal 7.9% of cases. E) Method of prevention of used in the operating theatre: Fluid heater 28.1%, air warming blanket 24.6%, F) 76.1% of anesthesiasts always warmed transfusion blood, 18.3% only warmed blood in case of transfusing more than 2 blood units, and 5.5% never warmed blood.

Conclusions: T is not integrated in routine intraoperative monitoring. A large number of anesthesiasts do not have the proper apparatus to measure it. However, availability does not guarantee its use. Potential consequences of hypothermia are underestimated by many anesthesiasts.


A-766
Internal jugular vein cannulation – comparison of central approach (palpation method) and posterior approach (non-palpation method)
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Background and Goal of Study: To compare the two approaches for internal jugular vein cannulation in patients undergoing renal transplant.

Materials and Methods: Sixty Hundred patients scheduled for kidney transplant were included in this study. Internal jugular vein cannulation was
performed either by central approach or posterior approach. Number of attempts, cannulation time and incidence of complications were recorded. **Results and Discussions:** Successful cannulation with few attempts was more in posterior approach (93.8%) than in conventional central approach (87.5%) and cannulation procedure time was also shorter in posterior approach (413.87 ± 88.02) than central approach (319.62 ± 69.58). Incidence of complications e.g. arterial puncture were less in posterior approach (7/80) compared to central approach (18/80).

**Conclusion(s):** Internal jugular vein cannulation by posterior approach (non-palpation method) is superior to central approach (palpation method) in terms of number of attempts, speed of cannulation and risk of arterial puncture.

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**A-767**

The training of the automated anaesthesia record
keeper with high fidelity human patient simulator for novice residents

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**Background and Goal of Study:** In Hamamatsu University Hospital, we made up an automated anesthesia record keeper (AARK) and it has been applied to all operations since 1994. It is also connected to a network which allows them to use a billing system after the operation. Although it is useful, it is hard to use correctly for novice residents. We have been using the HPS (High fidelity human patient simulator, METI, Florida, USA) for the education of residents and medical students. Recently, we started to make novice residents train with the AARK connected to the HPS system with the training of general anaesthesia.

**Materials and Methods:** We had already found out the common mistakes in the billing reports which novice residents tended to make. We compared the before rates and after rates of billing reports with mistakes at the commencement of this training. We also evaluated the efficiency of this training in some situations, for example, quickness to input the data in a certain situation, the times to correct the mistakes by themselves.

**Results and Discussions:** The rate of the billing reports with mistakes decreased significantly (P < 0.05). In all situations, we evaluated a large improvement in their performances of using AARK.

**Conclusions:** The training of the AARK with the HPS system was effective in order to decrease the common mistakes which novice residents tended to make. This training also improved their performances of using AARK.

**Reference:**


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**A-768**

Making sure of patients identity and side of surgery: the results of an audit on the triple check

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**Background and Goal of Study:** Checking patient’s identity and side of surgery is nowadays a formal recommendation.1 However, efficient prevention of errors demands an explicit method of checking, dependent on patient participation as well as a high compliance of clinicians. To achieve this objective, we audited the compliance to our “triple check”, an explicit method to ensure patient’s identity and side of surgery.

**Materials and Methods:** “Triple check” was developed by a group of surgeons, intensive care specialists and anaesthesiologists. Patients were asked for first and last names, date of birth and side of surgery. Then these data were compared to data present on patient’s wristband, and the mark of surgical side respectively, with information available on operating room schedule and in patient’s record. The audit was conducted between October 2003 and June 2004 via direct observation in both outpatient and inpatient operating rooms.

**Results and Discussions:** Between first and second quarters, compliance to the “triple check” significantly increased in all settings for patient’s identity and side of surgery checks. Between second and third quarters, it increased only for patient’s identity check. Non compliance was usually due to absence of wristband or mark of side, patients seen on the day prior to surgery and reluctance to ask patients directly.

**Conclusions:** Explicit definition of a method of checking patient’s identity and side of surgery is necessary. Our audit fostered this rigorous check but showed this can be limited by systemic and behavioural issues.

**Reference:**


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**A-769**

Extended-release epidural morphine does not increase risk of delayed respiratory depression

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**Background and Goal of Study:** The incidence of delayed respiratory depression with epidural morphine sulfate reportedly ranges from 0.8%–0.74%, and as high as 2.0% with intravenous (IV) patient-controlled analgesia (PCA) (1–3). DepoDur® is a single-dose, extended-release formulation of morphine sulfate recently approved in the United States for the control of postoperative pain. This analysis assessed whether the extended duration of analgesia (up to 48 hours) increased the rate of delayed respiratory depression relative to IV PCA or standard epidural morphine sulfate.

**Materials and Methods:** Respiratory depression was monitored in 7 phase II or III trials among patients administered single-dose epidural DepoDur (5, 10, 15, or 20 mg), standard epidural morphine sulfate 5mg, or IV PCA. Adverse events (AEs) potentially related to respiratory depression (respiratory depression, hypoxia, hypercapnia, dyspnea, apnea, and hyperventilation) at ≥2h and <48h postoperatively and requiring intervention with opioid antagonists were counted as delayed respiratory depression.

**Results and Discussion:** Of the 805 patients administered recommended doses of DepoDur (<20 mg for 510 patients <65 y of age and <15 mg for 95 patients ≥65 y of age), 19.2% had AEs potentially related to respiratory depression. For the 230 patients treated with IV PCA or standard epidural morphine sulfate, the overall rates of respiratory AEs were 52.7% and 12.4%, respectively. Twenty-two patients administered DepoDur met the criteria for respiratory depression, with the majority of events occurring ≥2h following surgery; 6 patients (1%) experienced delayed respiratory depression, which occurred at 6.3, 7.1, 7.6, 10.4, 14.2, and 14.5h after DepoDur administration.

**Conclusion(s):** Although DepoDur provides up to 48h of pain relief that is consistent with a continual release of morphine into the epidural space, the incidence of delayed respiratory depression is similar to the rates previously reported for standard epidural morphine sulfate.(1–3).

**References:**


**Acknowledgments:** This presentation was supported by SkyPharma, Inc. and Endo Pharmaceuticals Inc.

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**A-770**

Methicillin resistant staphylococci rapidly colonize the skin following cefazolin prophylaxis

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**Background and Goal of Study:** Preoperative antibiotic administration reduces postoperative wound infection after clean surgery (1). This prophylaxis

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also changes skin flora and helps emerging resistant bacterial strains. Postoperative infections caused by drug resistant pathogens are more difficult to treat and are associated with higher morbidity and mortality. In this study we examined the effect of perioperative cefazolin prophylaxis on the occurrence of methicillin resistant staphylococci in the skin flora.

**Materials and Methods:** Twenty male patients scheduled for cardiac surgery were included in the study. Age 56 ± 7 years. The first sample was obtained before the intravenous administration of 1g cefazolin (Totacef®), Bristol-Myers Squibb, USA). Other samples were taken following the surgery daily for a week.

Bacterial samples were taken with contact Rodac Petri plate (Neomod, Italy) from the chest. We also used plates containing cefazolin (30 μg·mL⁻¹) to select the resistant strains. The plates were incubated for 24 hours at 37°C and the colony forming units (cfu) were counted. The method is described in details elsewhere (2). Methicillin resistance encoding gene (mecA) in methicillin resistant coagulase negative staphylococci (CNS) was amplified by PCR and detected by agarose electrophoresis.

Statistical method: chi-square test.

**Results and Discussion:** Two patients had methicillin resistant (also cefazolin resistant) coagulase negative staphylococci before surgery. By the end of the study 17 of 20 patients had methicillin resistant CNS on the skin (Table 1).

<table>
<thead>
<tr>
<th>Sample collection</th>
<th>Before surgery</th>
<th>Post operative days</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>mecA+ CNS carriers</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

The occurrence of methicillin resistant CNS was significantly increased from the second the postoperative day (p < 0.05).

**Conclusion(s):** Our results suggest that methicillin resistant CNS strains rapidly colonize the skin following cardiac surgery where cefazolin prophylaxis was used. It is known that mecA gene can be transferred from CNS to Staphylococcus aureus (3). The use of other prophylactic agents than cephalosporins worth considering.

**References:**

**Acknowledgement:** Bolyai scholarship of the Hungarian Academy of Sciences supported this study.

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**A-772**

**Effect of surgeons work pattern on overnight emergency operating activity**

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**Background and Goal of Study:** The European working time directive (EWTD) has forced a change in work patterns for junior doctors. The CEPOD report recommends that only life or limb saving surgery should be undertaken overnight. We hypothesized that the number of non-urgent surgical cases during the night may increase if surgeons worked fewer hours on a shift pattern. This would be contrary to CEPOD guidelines. Our goal was to determine the effect of a trial of shift work on surgical activity at night.

**Materials and Methods:** We prospectively recorded activity in our emergency operating theatres from 00:00 to 08:00 hours for 21 weeks, divided into three 7 week periods. OC 1 was normal on call work, S was when surgical trainees worked night shifts, OC 2 was return to on call work. Data were collected from theatre logbooks. Start and finish of anaesthesia, operating surgeon, surgical specialty and anaesthetist were all recorded. During the study period only general surgical trainees altered their work pattern. Data were analysed using Kruskal-Wallis, ANOVA and Mann-Whitney U tests.

**Results and Discussions:**

<table>
<thead>
<tr>
<th>Study Period</th>
<th>Total operations in 7 weeks (n=)</th>
<th>Median (range) surgery duration (min) per night</th>
</tr>
</thead>
<tbody>
<tr>
<td>OC 1</td>
<td>20</td>
<td>0[270]</td>
</tr>
<tr>
<td>S</td>
<td>23</td>
<td>0[360]</td>
</tr>
<tr>
<td>OC 2</td>
<td>27</td>
<td>0[210]*</td>
</tr>
</tbody>
</table>

*p < 0.05.

**Conclusion(s):** During the period OC2 there was a significant decrease in both number and duration of surgical procedures, compared to S and OC 1. Contrary to our hypothesis surgical activity did not increase significantly during the shift study period. Rather, the experience of shift working appears to decrease surgeons operating activity on subsequent return to a 24 hour on call pattern.

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**A-773**

**Quality and quantity of non-technical skills correlate with quality of medical treatment in simulated critical incidents**

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**Background and Goal of Study:** The use of patient simulators for training of non technical skills (NTS), e.g. communication, leadership and planning in anaesthesia is increasing. We investigated whether quality and quantity of NTS correlated with quality of medical treatment in simulated critical situations.

**Materials and Methods:** After informed consent 42 anaesthesiologists were randomly assigned to two different training groups (TG1 vs. TG2). Both groups were homogenous for age, sex and professional experience. In a first session trainees had to treat a patient for malignant hyperthermia alone to get used to the simulated environment. In a following training of 3 hours, participants had to manage two simulated cases in teams of 2 (pulmonary embolism and myocar-
dial infarction). Each case was followed by video-based debriefing. Debriefing for TG1 was focussing on technical medical aspects of the cases while TG 2 was debriefed for NTS additionally. After one week each trainee had to manage a trauma patient with pneumothorax and head injury alone. The performance in this scenario was videotaped and evaluated scoring quality of medical treatment (QMT) and NTS (1). We also scored frequency of showing NTS (F).

**Results and Discussions:** Table 1 shows total scores for both groups in the trauma scenario (Mean ± SD).

<table>
<thead>
<tr>
<th>Scoring system</th>
<th>TG1 (n = 22)</th>
<th>TG2 (n = 20)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>QMT</td>
<td>45.4 ± 8.6</td>
<td>44.1 ± 8.7</td>
<td>0.879</td>
</tr>
<tr>
<td>NTS</td>
<td>43.5 ± 10.6</td>
<td>40.8 ± 9.4</td>
<td>0.412</td>
</tr>
<tr>
<td>F</td>
<td>137.5 ± 36.5</td>
<td>125.1 ± 27.4</td>
<td>0.016*</td>
</tr>
</tbody>
</table>

TG1 showed a significantly higher frequency of NTS. Different training formats had no influence on QMT or NTS.

Correlation of NTS and F was highly significant (r = 0.59, p < 0.01) and was also highly significant for NTS and QMT (r = 0.727, p < 0.01) over both groups. This might show that NTS need to be frequently used to produce a high NTS performance and a high quality of medical treatment.

**Conclusion(s):** Highly significant correlations of NTS with F and QMT were shown. Simulator training concepts might consider this finding to support trainees in using NTS more frequently.

**References:**
Background and Goal of Study: Commercial non-technical skill (NTS) trainings are offered by many simulator centres. Positive effects on crisis management performance are advertised. The study’s goal was to test the effectiveness of a modular NTS training of several hours in a controlled laboratory environment.

Materials and Methods: Two homogeneous groups absolved simulator training sessions of two different designs. Afterwards they were compared to each other for four crisis management categories using a behavioural marker-system (1). The NTS trainees were shown examples of good crisis management on videotapes, they were explicitly taught relevant strategies and their actions were thoroughly reviewed in video-based debriefings after the simulation sessions. Good communication in crisis situations represented a main focus because of its special suitability for teaching these skills and for assessing them via videotapes of the simulation sessions. The technical training (TT) group passed through two simulation sessions and received technical medical debriefings.

Results and Discussions: Analysis of variance was conducted for resource management, planning, leadership and communication. None of the four crisis management categories showed a significant superiority of the NTS group. In contrast, the TT group scored better in all of the four measurements. Especially for communication skills this result is surprising. The simulation experience per se might have a stronger effect on performance than explicit NTS-training components.

Conclusion(s): Positive effects on crisis management performance via an intensive modular NTS training could not be demonstrated. Technical simulator training led to very similar or even better results.


A-775

Simulator training is highly effective independently from explicitly teaching non-technical skills

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Background and Goal of Study: It is widely assumed that emphasizing the role of non technical skills (NTS) during debriefing sessions is essential for effective simulator training (1). We studied self-percieved competencies of anaesthesiologists before and after simulator training with or without emphasizing NTS.

Materials and Methods: After informed consent 42 anaesthesiologists were randomly assigned to two different training groups (TT vs. NTS). Self-percieved competencies of participants regarding crisis management were assessed by questionnaires given before (PRE) and after completion of training (POST) and 8 weeks after training (TRANSFER). Items were rated on a 6-point Likert scale (1 = low, 6 = high competency). All trainees received 5 hours of simulator training dealing with 4 identical critical incidents and were debriefed using videotapes of the actual scenarios. Debriefing for TT group was focussed on medical aspects of treatment. Debriefing of the NTS group additionally emphasized the importance of acute crisis resource management skills for critical situations in anaesthesia. The mean value of all questionnaire items was calculated to compare self-percieved competencies at PRE, POST and TRANSFER.

Results and Discussions: Self-percieved competencies of trainees (Mean ± SD) on a Likert Scale are shown in table.

<table>
<thead>
<tr>
<th>Time</th>
<th>TT (n = 22)</th>
<th>NTS (n = 20)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M/SD</td>
<td>M/SD</td>
</tr>
<tr>
<td>POST</td>
<td>4.03 ± 0.43</td>
<td>4.15 ± 0.73</td>
</tr>
<tr>
<td>TRANSFER</td>
<td>4.38 ± 0.44</td>
<td>4.51 ± 0.51</td>
</tr>
<tr>
<td>PRE</td>
<td>3.53 ± 0.64</td>
<td>3.65 ± 0.67</td>
</tr>
</tbody>
</table>

Self-percieved competencies were significantly increasing from PRE to POST (ANOVA p < 0.01) and from POST to TRANSFER (ANOVA p < 0.01) for both groups. Effects were not significantly different between groups, so different debriefing strategies had no significant influence on efficacy of training.

Conclusion(s): We could demonstrate a significant increase in self-percieved competencies of crisis management immediately after simulator training and 8 weeks later. Simulator training itself with video-based debriefing was proven an effective training tool independently from emphasizing NTS during debriefing.

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