

Oxygen Extraction Rate As A Tool To Control The Effect Of Hemodilution During Cardiopulmonary Bypass

H Suppan, W Londer, S Huber, P Rehak, H M?ler, B Rigler

Citation

H Suppan, W Londer, S Huber, P Rehak, H M?ler, B Rigler. *Oxygen Extraction Rate As A Tool To Control The Effect Of Hemodilution During Cardiopulmonary Bypass*. The Internet Journal of Anesthesiology. 1997 Volume 2 Number 2.

Abstract

INTRODUCTION

Despite recent advances in blood conservation techniques, up to 30% to 80% of patients undergoing open heart operations require allogeneic blood transfusions 1. The following methods of reducing allogeneic blood transfusions are well known: autologous blood donation, isovolemic hemodilution, hemodilution at the beginning and during extracorporeal circulation (ECC), hemofiltration and ultrafiltration to increase hemoconcentration, cell saver autotransfusion, reinfusion of blood from drainages, pharmacological influence on hemostasis, use of coated perfusion systems in extracorporeal perfusion, use of centrifugal pumps in extracorporeal perfusion, etc.

A prospective, randomized study was performed to test the effect of withdrawing blood during ECC by the perfusionist while controlling the oxygen extraction rate. The aim was to evaluate if a withdrawal of blood (400 ml) is tolerable concerning the O₂-extraction rate since a crucial upper limit of 22% - 30% during ECC has been postulated 2.

METHODS

40 male patients (62–78 years, mean age 69 years) undergoing CABG-procedures were randomized to either withdrawal of 400 ml blood from the cardiectomy reservoir with simultaneous substitution of crystalloid solutions 10 minutes after cross-clamping of the aorta (group I, n= 20) or performance of coronary artery bypass with standard ECC technique (group II, control group, n = 20). In both groups the oxygen extraction rate was measured.

In group I 400 ml of blood were temporarily stored in biopack-bags (Biotrans(r), Holland) during the ECC – with simultaneous substitution of crystalloid solutions – and controlled retransfusion during the rewarming or the post-bypass period was performed if the extraction rate increased

up to more than 25%.

In the control group (group II) CABG surgery was performed without hemodilution using standard ECC technique.

The oxygen extraction rate was calculated with the following formula 3 using a conventional software program (Excel(r), Microsoft(r), USA):

$$(1,39 \times \text{Hb}) \times \text{art. saturation} + (\text{PaO}_2 \times 0,003) = \text{ml O}_2 / 100 \text{ ml blood} = \text{CaO}_2$$

$$(1,39 \times \text{Hb}) \times \text{ven. saturation} + (\text{PvO}_2 \times 0,003) = \text{ml O}_2 / 100 \text{ ml blood} = \text{CvO}_2$$

$$\text{CaO}_2 \times \text{CO} \times 10 = \text{DO}_2$$

$$\text{CaO}_2 - \text{CvO}_2 = \text{avDO}_2 (\text{O}_2 / 100\text{ml blood})$$

$$\text{avDO}_2 \times \text{CO} \times 10 = \text{VO}_2$$

$$\text{VO}_2 / \text{DO}_2 = \text{oxygen extraction rate in \%}$$

Abbreviations:

PaO₂ = arterial O₂ pressure (mm Hg) CaO₂ = arterial oxygen concentration

PvO₂ = venous O₂ pressure (mm Hg) CvO₂ = venous oxygen concentration

DO₂ = capacity of oxygen transport CO = cardiac output

avDO₂ = arterio-venous difference in oxygen concentration

VO₂ = oxygen consumption / min

Points of measurement in both groups:

Point I: at 30°C blood temperature (at cross-clamping of the

aorta)

Point II: at 30°C blood temperature (10 min after withdrawal of 400 ml blood from the cardiotomy reservoir)

Point III: regaining 37°C blood temperature and after the end of the cross clamping period

STATISTICS

The hematocrit and the oxygen extraction rate were calculated by analysis of variance (ANOVA) with repeated measurements. In each group the oxygen extraction at different points of measurement was calculated with the student T-test.

RESULTS

A significant difference ($p < 0,05$) was seen regarding the oxygen extraction rate at point II between both groups. (Fig. 1, 2). In group I a significant difference ($p: 0,02$) was evident between points I and II (Fig. 1). No significant difference was seen regarding the hematocrit between any points in any of the two groups (Fig. 1, 2).

In 15% of the patients ($n = 3$) the withdrawn blood had to be retransfused to the cardiotomy reservoir due to extraction rate values more than 25%. In 85% the stored biopack bags could be handed over for further use.

Figure 1

Figure 1

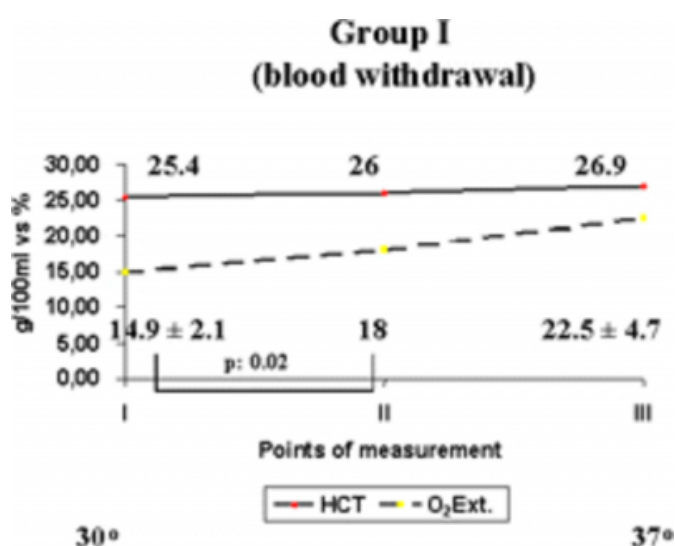


Figure 2

Figure 2

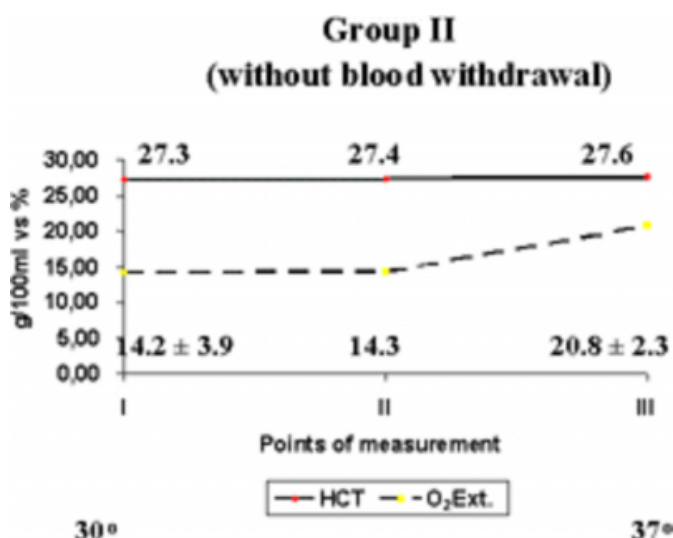


Fig. 1 and 2: all the values at points I, II and III are mean values ± standard deviation. Abbreviations: HCT = hematocrit in g/100 ml, O₂Ext = O₂-extraction in %

DISCUSSION

The preoperative autologous blood donation 4 is considered to be the safest and best method and should be applied in elective cardiac surgery. However, there are several contraindications as in patients with unstable angina, left main stenosis, heart failure in stage of decompensation, in aortic and mitral valve stenosis of higher degree (III – IV), in the case of a hemoglobin concentration less than 11 g/dl, in defects in hemostasis and in hemophilia or in congenital and aquired erythrocytal defects. Additionally, the costs for storage must not be left out of consideration.

Isovolemic hemodilution reflects one of the major methods in reducing blood transfusions 4. However, the simultaneous volume exchange with high-molecular or cristalloid solutions decreases the hematocrit and has several wellknown disadvantages like reduction of vital substances in the plasma, promotion of defects of hemostasis, increasing the perioperative risk of infection (immunosuppressive effect) or increasing the accumulation of extracellular/interstitial fluid (capillary leak syndrome).

Additionally, the equation of Fox 5 should be kept in mind that in case of low hematocrit levels a further increase of an already high blood flow will only lead to minimal changes in systemic oxygen consumption. Experimentally, at hematocrit values less than 17% - 20% an increase of cardiac output cannot maintain adequate oxygen distribution, as

shown in healthy canine hearts 6. The fact that a crucial lower limit of the hematocrit level exists is wellknown, however, the O₂-extraction rate is the limiting factor to control hemodilution.

Our method of measuring the oxygen extraction rate after withdrawing blood from the cardiotomy reservoir after initiation of ECC seems to be a good tool to provide information concerning the current O₂-consumption during ECC. The disadvantage is that the method can only be applied in about 85% of the patients.

Limitations of the study are that there was no long term evaluation of the morbidity at the intensive care unit (ICU) and that we cannot present results with isovolemic hemodilution. Additionally, measurements of lactate parameters after arrival at the ICU were not considered.

In conclusion, a priming free of allogeneic blood, a low volume in priming and an additional blood withdrawal

during ECC with hemodilution while controlling the oxygen extraction rate might reduce the need for allogeneic blood transfusions during open heart operations.

References

1. Shapira OM, Aldea GS, Treanor PR, Chartrand RM, DeAndrade KM, Lazar HL, Shemin RJ. Reduction of allogeneic blood transfusion after open heart operations by lowering cardiopulmonary bypass prime volume. *Ann Thorac Surg* 1998; 65: 724 - 30
2. Cardiovascular terms and formulas: Oxygen-transport variables.
www.dhep.astate.edu/patho/Cardiovascular/cardieterm.htm
3. Reich DL. Hemodynamic Monitoring In Kaplan JA (ed) , *Cardiac Anesthesia* 1993; 3rd edn: 289
4. Gombotz H, Kulier A. Reduktion des Fremdblutverbrauchs in der operativen Medizin. *Anaesthesist* 1995; 44: 191 - 218
5. Igarashi T, Sonehara D, Iwahashi K, Asahara H, Konishi A, Suwa K. Hemodynamics and oxygen consumption during warm heart surgery. *J. Anesthesiology* 1996; 10: 16 - 21
6. Crystal GJ. Myocardial oxygen supply-demand relations during isovolemic hemodilution *Adv Pharmacology* 1994; 31: 285 - 300

Author Information

Helmut Suppan, ECCP

Division of Cardiac Surgery, I. University Clinic of Surgery

Werner Londer, ECCP

Division of Cardiac Surgery, I. University Clinic of Surgery

Stefan Huber, MD

Division of Cardiac Surgery, I. University Clinic of Surgery

Peter Rehak, Ph.D

Division of Cardiac Surgery, I. University Clinic of Surgery

Heinrich M?ler, MD

Division of Cardiac Surgery, I. University Clinic of Surgery

Bruno Rigler, MD

Division of Cardiac Surgery, I. University Clinic of Surgery