Bispectral Index Profile During General Anaesthesia Using Nitrous Oxide For Lower Segment Caesarean Delivery

T Al Zahrani, O Ibraheim, A Turkistani, K Mazen

Citation

Abstract
Because of its antinociceptive effect N\textsubscript{2}O decreases the minimum alveolar concentration (MAC) of volatile anesthetics and may attenuate the increase in blood pressure and heart rate caused by surgical stimulation. Nitrous oxide used alone has no effect on BIS in humans even when it produces loss of consciousness. Patients undergoing lower segment caesarean section (LSCS) under general anesthesia are at increased risk of intraoperative awareness and subsequent recall. We have studied the effect of N\textsubscript{2}O/O\textsubscript{2}/sevoflurane anesthesia on bispectral index (BIS) values, versus O\textsubscript{2}/air/sevoflurane anesthesia for LSCS. Twenty ASA I&II patients receiving general anesthesia (GA) for elective LSCS were studied. During anesthesia, BIS values and other observations were recorded. Neither BIS nor mean blood pressure were significantly different between the two groups (p >0.05). A median BIS of 60 (range 40-70) recorded during surgery. Hemodynamic stability all over study period was satisfactory in both groups. We concluded that, BIS during O\textsubscript{2}/N\textsubscript{2}O/sevoflurane anesthesia for LSCS did not change significantly compared to O\textsubscript{2}/air/sevoflurane anesthesia.

INTRODUCTION
Early studies reported incidences of 7% for the recall of pain and 17% for occurrence of unpleasant dreams in patients undergoing general anesthesia for LSCS (1). BIS has been reported to measure the hypnotic component of the anesthetic state and has been shown to correlate well with the degree of sedation using many anesthetics (2,3). Inadequate hypnosis in the absence of opioid analgesia may account for the increased incidence of awareness in LSCS. Because of its antinociceptive effect, N\textsubscript{2}O decreases the minimum alveolar anesthetic concentration (MAC) of volatile anesthetics and may attenuate the increase in blood pressure and heart rate caused by surgical stimulation (4,5). N\textsubscript{2}O, alone has no effect on BIS in humans even when it produces loss of consciousness (6).

We have studied the effect of N\textsubscript{2}O/O\textsubscript{2}/sevoflurane anesthesia on BIS versus O\textsubscript{2}/air/sevoflurane anesthesia for LSCS.

PATIENTS & METHODS
After hospital Ethics Committee approval and written informed consent, 20 ASA I&II patients receiving general anesthesia for LSCS were studied. General anesthesia was conducted by same specialist anesthetist. All patients were premedicated with oral ranitidine 150 mg & 10mg metoclopramide 2 hr preoperatively and oral sodium citrate 30 ml 30 min before surgery. Standard monitoring included non-invasive blood pressure (NIBP), electrocardiogram (ECG), pulse oximeter (SpO\textsubscript{2}), end-tidal carbon dioxide (ETCO\textsubscript{2}), inspired oxygen fraction (FiO\textsubscript{2}), inspired nitrous oxide fraction (FiN\textsubscript{2}O), inspired and end-tidal fraction of sevoflurane. BIS was connected and numerical values displayed (A-1000 monitor, Aspect Medical Systems Inc., U.S.A.). The patients were randomly assigned to one of two groups (10 each) according to which gas mixture they received: 50% air/O\textsubscript{2} (air group) or 66% N\textsubscript{2}O/O\textsubscript{2} (N\textsubscript{2}O group). Before induction of anesthesia 0.5 mg /kg ketamine was given; then rapid sequence induction was performed with thiopentone and suxamethonium, at doses of 5 mg.kg\textsuperscript{-1} and 1 mg.kg\textsuperscript{-1} respectively. After tracheal intubations, anesthesia was maintained with sevoflurane (1 MAC) in both groups. Thereafter, 66% nitrous oxide in 33% oxygen was administered at fresh gas flows of 3 liters/min in (N\textsubscript{2}O group). Intravenous fentanyl 1 ug.kg\textsuperscript{-1} and synthetic oxytocin 10 units were administered to all patients. Muscle relaxation was maintained with Cisatracurium 0.06 mg/kg as initial bolus and additional boluses were given when required.

During anesthesia, BIS values and other observations were recorded at 2 min intervals until delivery at the following
stages, laryngoscope and endotracheal intubation, skin incision, uterine incision, delivery, subcutaneous layer closure, skin closure, cessation of inhalation agents, intravenous atropine and neostigmine administration, eye-opening and extubation. NO₂ was ceased at skin closure.

After administration of atropine and neostigmine, sevoflurane was turned off. The patient was asked at 1 min intervals to open the eyes. Then all patients were assessed in the postoperative recovery unit using Aldrete score and interviewed in the ward on the first postoperative day regarding the experience of dreaming or recall. Data are presented as mean ± SEM. Statistical analysis of the results was accomplished using Student’s t-test (two-tailed) for continuous data and Chi-square test for categorical data. Data were processed using Sigma Stat for Windows, Version 11 (SPSS11). P<0.05 was considered significant.

RESULTS
There was no significant difference between both groups regarding demographic data (Table1). Apgar score >6 in both groups was reported. There was no significant uterine atony or post partum hemorrhage reported in both groups. There was no significant difference between both groups regarding time intervals until extubation (P>0.05) (Table 2).

BIS values showed non significant differences between the two groups (P>0.05). A median BIS of 60 (range 40-70) was recorded on most occasions during surgery. Maximum reduction in BIS was found after orotracheal intubations from pre-induction values for both groups. However, these changes were comparable in the two groups (Figure 1).

There was no recall or dreaming reported by any patient in recovery room or 24 hr after surgery in both groups. Three cases in the air group and one case in N₂O group developed visual hallucination in the form of sharp lightening and red coloration following ketamine administration.

DISCUSSION
The incidence of awareness in obstetrics has been reported to be about 1.3% following rigid general anesthetic protocol and 0.4% if more flexible anesthetic approach is adopted (10). Unconscious learning may occur during emergency caesarean section (10). In a study using isolated forearm technique in 30 parturient, there was high incidence of intra-operative responsiveness without recall and the authors
concluded that allowing surgery to proceed immediately after endotracheal intubation did not provide adequate anesthesia at the time of skin incision \( (1) \). BIS is potentially useful aid for titration of inhalation agents in this group of patients, to ensure adequate hypnosis without compromising fetal outcome. It was reported that BIS reflects direct and indirect memory function during caesarean section \( (10) \).

In our study, the median BIS value was 60 at skin incision suggesting that an end-tidal sevoflurane with either nitrous oxide or air may be adequate. However, the Apgar scores and hemodynamic parameters did not suggest excessive drug dosing. BIS monitoring has proven to be useful in tracking hypnotic levels and improving titration of anesthetic drugs \((11,12)\). Below BIS value of 70, there is a very low probability of recall. The range between 60 and 70 may be considered deep sedation or light anesthesia. Below 60, the patient is usually unconscious. However, these BIS values with nitrous oxide had not been validated in pregnancy. In this observational study we recorded a median BIS value of 60 at skin incision which is similar to the BIS level at hypnosis reported by other investigators \( (13) \). At intubation, uterine incision and delivery, the median BIS value was 60, with a range of 40-60.

Other studies relied on recall to assess adequacy of anesthesia \((14,15,16)\). Even under hypnosis, only a fraction of information may be available for recall, although it may be remembered in other ways this may be due to spontaneous memory decay, or retrograde amnesia induced by drugs used after delivery \((17,18)\). We evaluated the component of explicit memory, but BIS monitoring during caesarean section has shown that learning can occur in the absence of conscious recall \((19)\). This weak form of explicit memory was reported in the absence of conscious recall at BIS level of 76.3 \((\pm3.0)\), the mean BIS during word presentation during the procedure \((20)\). In the absence of an adequately powered trial, it is not possible currently to conclude that BIS monitoring could reduce the incidence of awareness.

The current technique for caesarean section includes nitrous oxide, or air, the risk of awareness was not different in either group monitored by BIS. In studies involving inhalation of 70% nitrous oxide in healthy volunteers, adding nitrous oxide to the anesthetic produced no change of BIS values \((21)\). Moreover, with propofol and remifentanil, nitrous oxide prevented movement during tracheal intubation BIS did not change \((22)\). In conclusion, O/NO/sevoflurane anesthesia for LSCS did not alter BIS profile significantly compared to O/Air/sevoflurane.

**CORRESPONDENCE TO**

Osama Ibraheim
Riyadh 11472
P.O.Box 7805
Saudia Arabia

**References**

16. Cogan R, Spinnato JA. Pain and discomfort thresholds in...
Author Information

Tariq Al Zahrani, M.B.B.S.
Tutor in Anesthesia, Department of Anesthesia, King Khalid University Hospital

Osama Ibraheim, M.D.
Consultant, Department of Anesthesia, King Khalid University Hospital

Ahmed Turkistani, K.S.U.F.U.
Associate Professor, Department of Anesthesia, King Saud University

Khaled Mazen, M.D.
Senior Registrar, (Lecturer in Anesthesia, Ain Shams University, Egypt), Department of Anesthesia, King Khalid University Hospital