Comparison Of The Efficacy Of Two Low Fresh Gas Flow Techniques In Low Flow Anaesthesia

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Citation
S Kulandayan, L Ng, D Kamarudin. Comparison Of The Efficacy Of Two Low Fresh Gas Flow Techniques In Low Flow Anaesthesia. The Internet Journal of Anesthesiology. 2002 Volume 7 Number 1.

Abstract
In Queen Elizabeth Hospital, Kota Kinabalu, Sabah, Malaysia, most of the cases are performed under high gas flow even with the available high tech machine and gas monitoring. Unfamiliarity with low flow anaesthesia and fear of life-threatening sequelae to patients are the causes for reluctance to use low gas flow.

To review the advantages and claimed disadvantages in low flow anaesthesia, we conducted this study under the quality assurance program. This prospective randomized study uses two different low flow fresh gas flow techniques 1.5 and 1.0 lit / min. Fifty-four patients (ASA 1 & 2) undergoing elective surgical procedures were randomly allocated into two groups A & B of 27 patients each.

Group A received 1.5 lit / min (oxygen 0.5 lit and nitrous oxide 1.0 lit) while group B received 1.0 lit / min (oxygen 0.5 lit and nitrous oxide 0.5 lit). Gas and volatile variables were analyzed via the gas analyzer and arterial blood gases. There was no significant difference in gas analyzer monitoring and arterial blood gases in both groups.

Thus our study concluded and suggested the use of 1 liter (0.5 lit oxygen / 0.5 lit nitrous oxide) low flow technique in operations of intermediate and long duration with the availability of high tech anaesthetic machines and gas analyzers rather than 1.5 lit / minute thereby further reducing the cost expended on gases and volatile agents as well as minimizing operating room pollution and its consequent health hazard.

INTRODUCTION
Rebreathing means breathing some or all of previously exhaled gas. CO₂ is removed by soda lime. Remaining expired gas goes to fresh gas flow (FGF) and is rebreathed in. Recycling of gases reduces the fresh gas flow requirement. In low flow anaesthesia, inspired gas contains fresh gas flow and recycled exhaled gas.

According to Simmonescu’s suggestion, low flow means

- Low flow - 500 – 1000 ml / min
- Medium flow - 1 lit – 2 lit / min
- High flow - 2 – 4 lit / min

Low flow has been variously defined as FGF less than alveolar minute volume. For the performance of safe low flow anaesthesia, a modern anaesthetic machine and gas monitoring is needed. Education to increase awareness of staff regarding the advantages of low flow anesthesia such as the reduction in the consumption of gases and vapor (expensive volatiles-sevoflurane, isoflurane and desflurane) and therefore cost, as well as reduction in patient’s heat loss (latent heat of vaporization) and preservation of mucociliary clearance at respiratory tract. Reduction in operation theatre pollution (believed to be related to an increase in the rate of spontaneous abortion, liver disease, headache and tiredness) and reduction in environmental pollution (destruction of ozone layer and green house effect) in the long term are other advantages of using low flow anaesthesia.

The most quoted reason for the reluctance to use this technique is unfamiliarity. Risk of hypoxia and hypercarbia, over or under usage of volatiles, accumulation of potentially toxic gases (CO, methane acetone etc.) are the possible disadvantages.

The disadvantages can be overcome by proper training,
Comparison Of The Efficacy Of Two Low Fresh Gas Flow Techniques In Low Flow Anaesthesia

 regular usage, understanding the uptake kinetics of anaesthetic gases, suitable monitoring devices and efficient means of carbon dioxide absorption, all of which will make the low flow technique a safe technique.

Objective: To compare the efficacy of two fresh gas low flow techniques in the daily use of controlled general anaesthesia and thereby reduce the usage of medical gases and volatile agents in order to reduce the cost and theatre pollution.

STANDARDIZATION

Low flow anaesthesia was used in intermediate to long duration operations. High flow was given for 10 minutes at induction and during reversal to allow the rapid uptake and removal of anesthetic gases respectively. The anesthetic equipment should have a flow meter with small graduations (100 ml), circle system- CO2 absorber, vaporizer outside the circuit (VOC), calibrated flow compensated vaporizers and bag in the bellows ventilator.

The entire breathing system should be leak proof. The leak test for anaesthetic machine and for the breathing circuit was performed before starting as follows:-

Leak test for anaesthesia machine- a rubber suction bulb (this may be modified from the bulb used in sphygmomanometer ) was completely deflated and then attached to the common gas outlet. The bulb was observed for 10 seconds. It should not reinflate as reinflation indicated that entrainment of air from the atmosphere through a leak in the anaesthetic machine had occurred.

Leak test for breathing circuit- the pressure in the breathing system was increased to 50 cm of water by completely closing the expiratory valve and occluding the patient end. The fresh gas flow required to maintain this pressure was checked and for low flow techniques to be used correctly, FGF should be 100 ml per minute.

High flow removed nitrogen from the patient and circuit. Denitrogenation speeded up the rate of uptake of volatile anaesthetic. High flow was maintained for 10 minutes before switching to low flow according to the group in the study.

VOC delivered less than the dial setting of volatile agent when low flow was used while the uptake of nitrous oxide reduced with time as the body got saturated.

Minimum oxygen concentration used in low flow is 33- 35%

MONITORING

The ventilator were equipped with low pressure or disconnection alarms, airway pressure gauge and had an oxygen sensor to measure oxygen concentration.

A multigas analyzer was used to continuously measure the inspired / expired end tidal concentration of oxygen, carbon dioxide, nitrous oxide and volatile concentration as well as mean alveolar concentration or MAC. An oxygen analyzer was considered mandatory to avoid hypoxic mixtures being delivered to the patients. Gas extracted through the multigas analyzer was returned to the circuit.

Standard monitoring was carried out including pulse oximetry, non-invasive blood pressure, ECG and end tidal CO2.

METHODS AND MATERIALS

Informed consent from each patient and approval from the ethics committee were obtained. ASA grade 1 & 2 patients were accepted for this study. Before starting the case, routine check of machine including leak proof test and the monitors were performed. All the cases were premedicated with oral midazolam, and were administered controlled general anaesthesia using propofol/thiopentone, narcotics, esmeron, isoflurane and reversal agent.

In this prospective randomized study, we divided the patients into two groups

Figure 1

<table>
<thead>
<tr>
<th>Group A</th>
<th>Group B</th>
</tr>
</thead>
<tbody>
<tr>
<td>27 cases</td>
<td>27 cases</td>
</tr>
<tr>
<td>Low flow 1.5 lit / min</td>
<td>Low flow 1.0 lit / min</td>
</tr>
<tr>
<td>Oxygen 0.5 lit / min</td>
<td>Oxygen 0.5 lit / min</td>
</tr>
<tr>
<td>Nitrous oxide 1 lit / min</td>
<td>Nitrous oxide 0.5 lit / min</td>
</tr>
</tbody>
</table>

Isoflurane is the volatile agent, 1 MAC is maintained.

Age, sex and duration of surgery.
Patients were started with high flow induction for 10 minutes, followed by low flow settings according to the group. Monitoring carried out included pulse oximetry, ETCO\textsubscript{2}, ECG, noninvasive blood pressure, and gas analyzer which monitored the inspired / expired values of oxygen, volatiles and MAC. All the findings were documented in the form prepared for the study and also in the anaesthesia record form.

Arterial blood gases were sampled for analysis at 10 minutes before the end of surgery.

The results were analyzed.

1 MAC isoflurane was maintained throughout the operation and was switched off 10-15 min before the end of operation.

Ventilator settings- Tidal volume 10ml / kg, RR- 12/ min, I: E ratio 1:2

Modern anaesthesia machines and monitoring were used in this study.
Comparison Of The Efficacy Of Two Low Fresh Gas Flow Techniques In Low Flow Anaesthesia

in low flow. Whitcher in 1986 showed an over 60% reduction in potent anaesthetic use with low flow, thus saving 120,000 dollars / year for a hospital of moderate size.

Forrester reported a 25% reduction in isoflurane use when 75-80% of cases were done under low flow anaesthesia. Benefits of rebreathing, cost savings, humidification, heat conservation and reduction in pollution can be achieved by using low flow technique.

Pollution is not reduced to zero because of leaks through the circuit and losses during high flow periods at induction and emergence from anaesthesia.

Although many anaesthetic machines are equipped with circle breathing system, controlled GA using high fresh gas flow remains frequently performed. Modern anaesthetic machines and gas analyzers are needed for the safe use of low flow technique.

Monitoring inhaled and exhaled gas concentrations will likely become an obligatory safe standard in many countries. For vaporizer outside circuit, in high flow, inspired concentration is equal to vaporizer concentration setting but in low flow, inspired concentration is less than the setting due to a long time constant for achieving desired inspired concentration. Therefore, a higher vaporizer concentration must be set.

In long term low flow anaesthesia using sevoflurane, compound A, the degradation product, had been shown to cause histological renal tubular damage in rats, but awaits clarification in humans.

Monitor sample circuit removes gases at rates 50-250 ml / min but that is insignificant

In our study, two low flow techniques were used with modern anaesthetic machines and multigas analyzer setup. The difference in inspired / expired oxygen in the gas analyzer monitor shows constant uptake of oxygen throughout anaesthesia, uptake of nitrous oxide reduced within 15-30 minutes in group A and 30 – 45 minutes in group B. Vital signs were stable in both groups and ABG at the end of surgery showed compensated pH, respiratory alkalosis and metabolic acidosis in both groups. This may be due to hyperventilation in controlled general anaesthesia. Thus, there was no significant difference in inspired / expired oxygen and nitrous oxide, hemodynamic parameters and arterial blood gas analysis in both groups.

This study suggests that both low flow techniques are safe with new high tech anaesthesia machines using soda lime and gas analyzers thereby reducing the usage of gases and volatiles, cost and pollution.

Figure 6

<table>
<thead>
<tr>
<th>% Rebreathing</th>
<th>High Flow</th>
<th>Low Flow</th>
<th>Minimal Flow closed circuit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>86%</td>
<td>97-100%</td>
</tr>
</tbody>
</table>

Estimate of annual anaesthetic gas consumption & cost reduction in Germany and UK

Figure 7

A Comparison of 1 and 2 hour anaesthetic costs and potential savings over the range of fresh gas flows (Prys-Roberts and Brown, 1996)

Figure 8

Datex Ohmeda Anaesthesia machine and monitor:
CONCLUSION

In Queen Elizabeth Hospital, Kota Kinabalu, Sabah, Malaysia, most of the cases are performed under high gas flow techniques despite the operation theatre being well equipped with modern anaesthetic machines with circle breathing systems and monitors.

Hypoxia, hypercarbia, under or overdosage of volatiles are the prejudice points against low flow, to be kept in mind before using low flow technique. This technique needs high tech anaesthesia machines and multigas analyzers to ensure safety of patient.

Low flow anaesthesia reduces the cost spent on gases, environmental pollution and reduces the heat loss in patients by latent heat of vaporization as well as preserving the mucociliary clearance of patients’ respiratory tract.

In the study, high flow was used during induction, reversal, maintenance for 5 minutes every hour and for any disconnection in the breathing circuit / ventilator during maintenance to ensure adequate depth of anaesthesia was maintained. There were no complaints of awareness from the patients however.

Though our QAP study shows no significant difference in both low flow techniques, it is preferable and suggested to use 1 lit low flow (oxygen 0.5 l and 0.5 l nitrous oxide) technique in intermediate and long duration surgical procedures as 1 litre low flow will further reduce the cost and pollution compared to 1.5 lit.

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