Epitomes

Important Advances in Clinical Medicine

Anesthesiology

The Scientific Board of the California Medical Association presents the following inventory of items of progress in anesthesiology. Each item, in the judgment of a panel of knowledgeable physicians, has recently become reasonably firmly established, both as to scientific fact and important clinical significance. The items are presented in simple epitome and an authoritative reference, both to the item itself and to the subject as a whole, is generally given for those who may be unfamiliar with a particular item. The purpose is to assist busy practitioners, students, research workers or scholars to stay abreast of these items of progress in anesthesiology that have recently achieved a substantial degree of authoritative acceptance, whether in their own field of special interest or another.

The items of progress listed below were selected by the Advisory Panel to the Section on Anesthesiology of the California Medical Association and the summaries were prepared under its direction.

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Outpatient Anesthesia Techniques: Continuous Intravenous Infusion of Anesthetic Agents

OUTPATIENT SURGICAL PROCEDURES have become increasingly popular because of savings in terms of both hospital beds and expenses. A long-standing contention of anesthesiologists has been that inhaled anesthetics (such as halothane and enflurane) are superior to intravenously given (IV) anesthetics for outpatient anesthesia because volatile agents are more controllable. Traditionally, IV anesthetics have been administered by intermittent bolus injections. By using continuous infusion techniques, anesthetists can more closely titrate these anesthetics to meet the changing needs of a patient during an operation. Recent studies of outpatients undergoing minor surgical procedures indicate that the continuous infusion of IV anesthetics (such as ketamine hydrochloride) and analgesics (such as fentanyl citrate) results in a 40% to 50% decrease in the drug dosage requirement and a significantly shorter recovery period when compared with the traditional intermittent bolus technique. After a standard thiopental sodium induction, a continuous infusion of fentanyl (5 to 10 μg per minute) or ketamine (2 to 5 mg per minute) was used to supplement nitrous oxide. Both fentanyl and ketamine were associated with intraoperative and postoperative problems. However, the new opioid analgesic, alfentanil hydrochloride, appears to offer significant clinical advantages—that is, less respiratory depression and more rapid recovery—over fentanyl when administered by continuous infusion as an adjuvant to nitrous oxide on an outpatient basis. Of the available IV anesthetic drugs, methohexital sodium may prove to be the most useful for outpatients because its use is associated with a rapid recovery and few, if any, side effects. Additionally, methohexital can be administered by continuous infusion to supplement nitrous oxide. In outpatients receiving fentanyl (75 to 100 μg) or meperidine hydrochloride (50 to 75 mg) for premedication, an induction dose of methohexital, 1.5 mg per kg of body weight, followed by a maintenance infusion of methohexital, 3 to 6 mg per minute, proved to be an excellent adjuvant to nitrous oxide. Further studies are under way to evaluate the use of a methohexital IV infusion for sedation during local or regional procedures. Controlled studies comparing these infusion techniques with the use of volatile anesthetic agents (such as isoflurane) on an outpatient basis are needed.

A wide variety of delivery systems are available for continuous IV administration of anesthetic agents. Although volumetric or syringe pumps are useful for prolonged infusions, simple drip chamber or flow-controller devices are adequate in an outpatient setting. In fact, the drip chamber containing the drug to be infused can be piggy-backed into an existing intravenous line (with or without a flow-controller device). If sterility is maintained, the same infusion system can be used in several different patients. Thus, expensive infusion pumps are unnecessary when continuous administration techniques are used for brief surgical procedures.

In conclusion, continuous intravenous administration of anesthetics (and analgesics) is an acceptable alternative to the volatile anesthetics used in the out-

patient setting. For outpatient procedures where volatile agents should probably be avoided (such as a midtrimester abortion), these adjunctive IV infusion techniques are simple to use and associated with a patient's rapid recovery and prompt discharge from the ambulatory surgery facility. With the increasing popularity of IV anesthetics, infusion pumps may soon become standard equipment on anesthesia machines.

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Perfluorochemical Emulsion—'Artificial Blood': What Is It?

LELAND CLARK dramatically proved the oxygen-carrying ability of perfluorochemicals by completely submerging a mouse in the liquid for 20 minutes and having it survive. These inert liquids have extremely high oxygen solubilities, about 20 times that of water—that is, 45 ml per dl at 760 torr oxygen partial pressure (tension; Po_2) and 37°C; perfluorochemicals are also immiscible in water and are acutely toxic when given intravenously because they form a bolus that acts as a pulmonary embolus. In 1968 it was shown that a fine emulsion of perfluorochemical in saline solution could act as an erythrocyte substitute in rats that have had exchange transfusions. The first human volunteers received the perfluorochemical emulsion, Fluosol-DA (20%), in 1979. Fluosol-DA has 14 grams per dl of perfluorodecalin and 6 grams per dl of perfluorotripropylamine emulsified in a solution of salts and hydroxyethyl starch. Because Fluosol-DA contains only 20 grams per dl of perfluorochemical with an approximate density of 1.8 grams per ml, in a patient having a complete exchange transfusion (fluorocrit about 12%, ml per dl of perfluorochemical in the plasma) at 500 torr arterial oxygen partial pressure (Pao_2), the perfluorochemical would carry about 6 ml per dl of oxygen. This may seem small compared with a normal arterial oxygen content of blood at room air of 20 ml per dl; but because the perfluorochemical transports oxygen by direct solubility as does plasma, nearly all the oxygen in the perfluorochemical is consumed. That is, if an exchange-transfused patient had an arterial-venous oxygen content difference of 4 ml per dl, the mixed venous Po_2 would be more than 150 torr.

Recent clinical studies in the United States and Japan have confirmed that perfluorochemicals do transport the expected volume of oxygen and in spite of the small amounts of perfluorochemical given (fluorocrit 3%), there were significant increases in oxygen content, oxygen consumption and mixed venous hemoglobin saturation. The perfluorochemical is cleared by expiration and has a plasma half-life of about 18 hours. As an erythrocyte substitute, perfluorochemical emulsions will only be beneficial in acute emergencies until blood is available. Because perfluorochemicals carry oxygen by simple solubility like plasma, the amount of oxygen carried is directly related to the Pao_2. It has been shown in a clinical study that a significant increase in oxygen content could only be measured when the perfluorochemical was in the presence of high Pao_2 values (more than 300 torr).

One of the most intriguing properties of perfluorochemical emulsions is the extremely small size of the emulsion droplets, 0.1 micron (1/70 the size of an erythrocyte). With the potential to transport more oxygen through small constricted blood vessels, these fluids may be beneficial in any acute ischemic disease process. Glogar and co-workers showed a significant myocardial protective effect when these fluids were given in an animal model of myocardial infarction. Peerless and colleagues found similar results in an animal model of acute cerebral ischemia.

Perfluorochemical emulsions are intriguing new fluids that should be thought of as "supercharged" plasma and not erythrocyte substitutes. They may support anemic patients but require high oxygen tensions. They will probably play a significant role in the future in emergency treatment of ischemic disease.

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Transcutaneous Oxygen Partial Pressure: A Continuous Noninvasive Monitor of Tissue Oxygenation

A TRANSCUTANEOUS OXYGEN SENSOR measures oxygen partial pressure (Po_2) noninvasively at the skin surface with the same Clark polarographic electrode that is used in conventional blood gas machines. For the sensor to record significant Po_2 values with fast response times on adult skin, the electrode must be heated to 44°C to 45°C. Heating the skin causes the stratum corneum to change structure, which is thought to increase its permeability to oxygen. Heating also causes hyperemia of the dermal capillary bed and is