Assessment of the Lower Limit for Cerebral Perfusion Pressure in Severe Head Injuries by Bedside Monitoring of Regional Energy Metabolism

Carl-Henrik Nordström, M.D., Ph.D.,* Peter Reinstrop, M.D., Ph.D., † Wangbin Xu, M.D., ‡ Anna Gärdenfors, M.D., § Urban Ungerstedt, M.D., Ph.D., ‡

Background: In patients with severe traumatic brain lesions, the lower limit for cerebral perfusion pressure (CPP) is controversial. The aim of this prospective study was to assess this limit from bedside measurements of cerebral energy metabolism and to clarify whether the penumbra zone surrounding a focal lesion is more sensitive to a decrease in CPP than less-injured areas.

Methods: Fifty patients with severe head injury were included after evacuation of an intracranial hematoma and/or focal brain contusion. They were treated according to intensive care routine (Lund concept), including continuous monitoring of intracranial pressure. One microdialysis catheter was inserted in less-injured brain tissue (“better” position), and one or two catheters were inserted into the boundary of injured cerebral cortex (“worse” position). Concentrations of glucose, pyruvate, and lactate were analyzed and displayed bedside and were related to CPP (n = 29,495).

Results: Mean interstitial glucose concentration was unaffected by the level of the CPP within the studied ranges. Increases in lactate concentration (P = 0.0008) and lactate–pyruvate ratio (P = 0.01) were obtained in the “worse” but not in the “better” position at CPP less than 50 mmHg compared with the same positions at CPP greater than 50 mmHg.

Conclusions: The study results support the view that CPP may be reduced to 50 mmHg in patients with severe traumatic brain lesions, provided that the physiologic and pharmacologic principles of the Lund concept are recognized. In the individual patient, preservation of normal concentrations of energy metabolites within cerebral areas at risk can be guaranteed by intracerebral microdialysis and bedside biochemical analyses.

IN patients with severe traumatic brain injuries, death is usually caused by an intractable increase in intracranial pressure (ICP). ICP is monitored continuously in most neurosurgical centers, and there is consensus concerning most aspects of initial management (controlled ventilation, avoidance of hypovolemia and arterial hypotension, blood volume substitution, early evacuation of focal intracranial mass lesions). However, in the treatment protocols for sustained increase in ICP, the strategies differ widely.1 In recent years, the varying views have been polarized into two groups. One group focuses on cerebral perfusion pressure (CPP) and cerebral blood flow (CBF) and includes pharmacologically induced increases in mean arterial blood pressure (MAP) and CPP to improve CBF.2–6 In these treatment protocols, MAP and CPP are increased by intravenous infusion of isotropic drugs and/or vasopressors (norepinephrine, phenylephrine), and the treatments are considered to be CPP targeted or CBF targeted.1–6 The second group focuses on reduction of ICP by decreasing one or more of the intracranial volumes (volume targeted, Lund concept). According to the Lund concept, an increased reabsorption of intracerebral water is accomplished by maintaining a normal colloid osmotic pressure (with blood transfusion and albumin infusion) in combination with a reduction in intracapillary hydrostatic pressure.7–9 The physiologic and pharmacologic principles behind the two therapeutic concepts are incompatible. For the CPP-targeted therapy, the lower acceptable limit for CPP has often been set at 70 mmHg.1,3–6 but considerably higher CPP has also been recommended.10 For the Lund concept, the lower limit has been set at 50 mmHg.7,8 Intracerebral microdialysis with bedside monitoring of metabolites reflecting cerebral energy metabolism may offer a possibility to evaluate the lowest acceptable CPP in the individual patient.11 In the present study, microdialysis catheters were inserted into less-injured (“better”), as well as more-injured (“worse”), parts of the brain in patients with severe head injuries. The objectives of the study were to investigate whether cerebral energy metabolism was more at risk in the worse position than in the better position during a decrease in CPP and to assess the lower acceptable limit for CPP for the two regions. We report the results of 29,495 bedside biochemical analyses (glucose, pyruvate, lactate) in relation to CPP in 50 patients with severe head injuries.
Materials and Methods

Patients
A total of 50 consecutively presenting patients with severe traumatic brain lesions (posttraumatic coma > 6 h) were included in this prospective study. The mean age of the patients was 43 ± 18 yr (range, 2–75 yr). All patients were treated surgically with evacuation of focal, intracranial mass lesions. Thirty-one patients had an acute subdural hematoma (2 combined with an extradural hematoma, 15 combined with focal cerebral contusions), 3 patients had a combination of focal contusion and extradural hematoma, 15 patients had pure focal hemorrhagic contusions, and 1 patient had a pure epidural hematoma. The clinical decision to evacuate the focal lesion was always based on computed tomography scan, neurologic state on admission, and, in many cases, repeated neurologic evaluation. All patients received an intraventricular catheter for continuous ICP monitoring. Seven patients died during the intensive care period—all because of increased ICP (mean age, 45 ± 25 yr; range, 15–75 yr).

All treatment was in accordance with clinical routine in our department, and the ethical committee of Lund University Medical Faculty (Lund, Sweden) has approved the use of microdialysis with multiple intracerebral catheters as a routine procedure in patients with severe traumatic brain injuries. Informed consent was obtained from relatives of all patients.

Microdialysis Technique
The technique for intracerebral microdialysis and bedside biochemical monitoring has been described in detail elsewhere. Briefly, during surgery, one or two microdialysis probes (CMA 70, molecular cutoff of 20 kd; CMA Microdialysis, Stockholm, Sweden) were inserted into the brain tissue surrounding the evacuated focal mass lesion (worse position). In addition, one microdialysis catheter was inserted into the cerebral cortex via a separate burr hole close to that used for ICP recording (better position).

Figure 1 shows the positioning of the intracerebral microdialysis probes in a typical case. A large, hemorrhagic frontal contusion (fig. 1A) was evacuated, and two microdialysis probes were positioned in the surrounding (worse position) brain tissue (fig. 1B). The ventricular catheter used for ICP monitoring is shown in figures 1B and 1C. Figure 1C also shows the position of the third intracerebral probe (better position) in relation to the ventricular catheter.

The catheters were perfused (Perfusion Fluid; CMA Microdialysis, Stockholm, Sweden) at 0.3 μl/min from a microinfusion pump (CMA 106; CMA Microdialysis, Stockholm, Sweden), and samples (median number per patient, 114; range, 12–532) were collected every 60 min for bedside analyses of glucose, pyruvate, and lactate.

Fig. 1. (A) A large, hemorrhagic frontal contusion was evacuated. (B) Two microdialysis probes, (1) and (2), were positioned in surrounding (“worse”) brain tissue, and a ventricular catheter (v.c.) was inserted. (C) A third microdialysis probe (3) was placed in the opposite (“better”) hemisphere.
tate using a CMA 600 Microdialysis Analyzer (CMA Microdialysis, Stockholm, Sweden). Since the analytical techniques were partly developed during the study, it was possible to measure pyruvate bedside in only 33 of the patients. All biochemical data were compared with the reference concentrations in normal human brain obtained using identical microdialysis and analytical techniques.

**Treatment during Intensive Care**

All patients were sedated and intubated with controlled ventilation. Neuronal blockade was not used. Stress response was reduced by liberal use of midazolam (5–20 mg/h) and fentanyl (2–5 μg · kg⁻¹ · hr⁻¹), and continuous infusion of low-dose thiopental (0.5–3 mg · kg⁻¹ · h⁻¹) was also used in most patients. Increased ICP was treated according to the protocol (Lund concept) in our department. The protocol includes antihypertensive and antistress treatment with a combination of the β₂-antagonist metoprolol (0.2–0.3 mg · kg⁻¹ · 24 h⁻¹ intravenously) and the α₂-agonist clonidine (0.4–0.8 μg/kg every 4–6 h intravenously) and was initiated when the patient was clearly normovolemic, as determined by erythrocyte and albumin–plasma transfections to normal albumin and hemoglobin values and to a normal central venous pressure. A CPP of 60–70 mmHg was considered optimal, but, if necessary to control ICP, a CPP of 50 mmHg was accepted in adults. During episodes of high ICP and low CPP, intravenous infusion of dihydroergotamine was used in 11 patients but always at a lower dose and for a shorter duration than in previous studies.

**Statistics**

The statistical evaluation was performed in collaboration with Jan-Åke Nilsson, B.Sc., consulting statistician at the Department of Internal Medicine, Malmö University Hospital, Malmö, Sweden. Four ranges of CPP were chosen arbitrarily: less than 50 mmHg, 50–60 mmHg, 61–70 mmHg, and greater than 70 mmHg. Within each CPP range, the median concentrations of the biochemical variables obtained by intracerebral microdialysis, as well as the lactate–pyruvate ratio, were calculated for each patient. For each variable, five hypotheses were tested using the Wilcoxon matched pairs test for pairs of variables in the worse and better parts of the brain in relation to the CPP levels: worse part greater than 70 mmHg versus better part greater than 70 mmHg.

**Results**

For the entire group of 50 patients, MAP was 82 ± 15 mmHg (mean ± SD), and ICP was 14 ± 10 mmHg (mean ± SD) during the first 4 days after surgical evacuation of the focal mass lesions. The changes over time (mean ± SEM) for both parameters are shown in figure 2. During the first 6 h after surgery, ICP increased from worse part less than 50 versus better part less than 50, worse part less than 50 versus worse part greater than 70, worse part less than 50 versus worse part greater than 50, and better part less than 50 versus better part greater than 50. Due to repeated comparisons P ≤ 0.01 was considered statistically significant.

![Fig. 2. Mean values ± SEM (mmHg) for mean arterial blood pressure (MAP; top) and intracranial pressure (ICP; bottom) during the initial four postoperative days after evacuation of intracranial focal mass lesions in 50 patients with severe traumatic brain lesions. The data have been clustered to one value each hour.](image)

![Fig. 3. Mean values ± SEM for arterial Po2 (kPa), PCO2 (kPa), pH, and lactate concentration (ms) during the initial four postoperative days after evacuation of intracranial focal mass lesions in patients with severe traumatic brain lesions. The data have been clustered to one value each hour.](image)
and Related to the Level of Cerebral Perfusion Pressure

Table 1. Statistical Evaluation of Data Pairs for Glucose, Lactate, and Lactate–Pyruvate Ratio in Worse and Better Parts of the Brain and Related to the Level of Cerebral Perfusion Pressure

<table>
<thead>
<tr>
<th>Pair of variables</th>
<th>Glucose</th>
<th>Lactate</th>
<th>Lactate–Pyruvate Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Valid n</td>
<td>P</td>
<td>Valid n</td>
</tr>
<tr>
<td>Worse vs. Better, CPP mmHg</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Worse &gt; 70 vs. Better &gt; 70</td>
<td>43</td>
<td>0.86</td>
<td>48</td>
</tr>
<tr>
<td>Worse &lt; 50 vs. Better &lt; 50</td>
<td>23</td>
<td>0.58</td>
<td>28</td>
</tr>
<tr>
<td>Worse &lt; 50 vs. Worse &gt; 70</td>
<td>21</td>
<td>0.36</td>
<td>25</td>
</tr>
<tr>
<td>Worse &lt; 50 vs. Worse &gt; 70</td>
<td>21</td>
<td>0.36</td>
<td>28</td>
</tr>
<tr>
<td>Better &lt; 50 vs. Better &gt; 50</td>
<td>25</td>
<td>0.78</td>
<td>35</td>
</tr>
</tbody>
</table>

CPP = cerebral perfusion pressure; LP = lactate–pyruvate.

Anesthesiology. V 98, No 4, Apr 2005
Discussion

According to the Lund concept, a decrease in CPP is not a goal in itself but a measure to decrease brain volume by a slow and continuous transcapillary reabsorption of water. During physiologic conditions, regulation of brain volume is mainly determined by the blood–brain barrier (BBB). The intact BBB has a very low permeability for large molecules like colloidis but also for crystalloids. Accordingly, the total osmotic pressure is essentially determined by the crystalloids (primarily sodium and chloride) and amounts to approximately 5.700 mmHg. An influx of water across the BBB due to increased intracapillary hydrostatic pressure therefore will not be accompanied by crystalloids, and an osmotic pressure gradient working in the opposite direction will immediately be created, thereby counteracting further water influx. During physiologic conditions, a change in intracapillary hydrostatic pressure or colloidal osmotic pressure therefore will have only minor effects on brain volume. During pathophysiologic conditions with a partial or complete disruption of the BBB, variations in these two variables will, however, be of crucial importance for brain volume and ICP.9

The lower limit of CPP for maintenance of cerebral energy metabolism varies between individuals and is dependent on intracranial and extracranial pathophysiologic conditions and whether the decrease in CPP is caused by an increase in ICP or by a decrease in MAP (e.g., due to hypovolemia). In experimental studies of normal rat brain, a sudden perturbation of cerebral energy metabolism occurred when CPP decreased to less than 30 mmHg due to increased ICP.18 The injured brain would be expected to be more sensitive to a decrease in CPP. In a rat model, contusion volume following impact injury was minimized when CPP was maintained between 70 and 105 mmHg and was increased at CPP less than 60 mmHg, as well as at CPP greater than 105 mmHg.19 However, in the only randomized clinical trial that has examined the consequences of different levels of CPP, the investigators concluded that there is no compelling reason to increase CPP beyond that required to adequately perfuse the brain, and that a CPP of 60 mmHg was probably adequate for most brain trauma patients.1 20

Our study supports the view that more-injured brain tissue (worse position) is more sensitive to a decrease in CPP than less-injured brain tissue (better position), as revealed by significant increases in lactate concentration and lactate–pyruvate ratio at CPP less than 50 mmHg. At a normal hemoglobin concentration (150 g/l) and at 95% oxygen saturation, human arterial blood contains approximately 9 micromoles of oxygen per milliliter, and the arteriovenous oxygen difference is approximately 3 μmol/ml.21 Thus, if CBF is reduced to approximately one third, then, theoretically, all oxygen will be extracted. In practice, such a reduction in CBF cannot maintain the normal oxygen supply since the reduction in PO2 will also decrease the oxygen diffusion gradient. For glucose, the following approximate concentrations have been described for humans: arterial concentration,
supply to the brain will be insufficiently, during a gradual decrease in CBF, the oxygen supply to the brain will be insufficient before the supply of glucose is seriously decreased.

Lactate and pyruvate are considered to be diffusible through cell membranes, and measurements of the extracellular lactate-pyruvate ratio therefore should reflect cytoplasmatic redox changes, which can be expressed in terms of the lactate dehydrogenase equilibrium:

\[
\frac{[\text{NADH}][\text{H}^+]}{[\text{NAD}^+]_r} = \frac{[\text{Lactate}]}{[\text{Pyruvate}]} \times K_{LDH}
\]

Accordingly, the lactate-pyruvate ratio reflects cytoplasmatic pH and regional oxygen availability. We therefore interpret the increases in lactate concentration and lactate-pyruvate ratio in the worse position at CPP less than 50 mmHg (table 1) as indicators of insufficient tissue oxygenation.

In our patients, the lactate level was consistently higher in the worse position than in the better position (table 1). The exact cause for this difference is not known, but compromised regional blood flow is a most plausible explanation. Increasing CPP might then be expected to improve microcirculation and tissue oxygenation in the worse position. However, our biochemical data do not support this assumption: at CPP greater than 70 mmHg, lactate concentration was still significantly higher in the worse position than in the better position, which seems to be in agreement with clinical experiences. The data indicate that at CPP less than 50 mmHg, tissue oxygenation may be insufficient in severely injured parts of the brain, as shown by increases in tissue lactate concentration and lactate-pyruvate ratio in the worse, but not in the better, position (table 1).

In conclusion, our study supports the view that, if necessary, CPP may be reduced to 50 mmHg in patients with severe traumatic brain lesions, provided that the physiologic and pharmacologic principles of the Lund concept are recognized. However, it should be recognized that variations among patients might be considerable. In the individual patient, preservation of normal cerebral energy metabolism within areas at risk during a decrease in CPP can be guaranteed by intracerebral microdialysis and bedside biochemical analyses. The optimal treatment protocol for patients with severe traumatic brain lesions and increased ICP probably differs among patients. Therefore, bedside monitoring of biochemical variables may be useful in optimizing the treatment of the individual patient and to evaluate various therapeutic alternatives.

The authors thank Katarina Nielsen, R.N. (Research Nurse, Department of Neurosurgery, Lund University Hospital, Lund, Sweden), for her help with the microdialysis equipment and biochemical analyses.

References