Bispectral Index Decreased to “0” in Propofol Anesthesia after a Cross-clamping of Descending Thoracic Aorta

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THE Bispectral Index (BIS®) monitor (BIS® monitor; Aspect Medical System, Inc., Newton, MA) integrates electroencephalographic data via a proprietary algorithm based on empirical data into a nominal 100 to 0 scale, in which 100 represents the awake state and 0 represents the isoelectric electroencephalogram. The BIS® monitor is highly capable of correctly predicting both the loss and recovery of consciousness and has been reported to be more reliable in assessing the level of sedation and hypnosis during surgery than other available processed electroencephalogram algorithms. It also has been used clinically to guide anesthetic drug administration and to quantify the pharmacokinetic and pharmacodynamic action of anesthetic drugs in the laboratory setting.

We report a case of a rapid decrease in the BIS score during total intravenous anesthesia using propofol after cross-clamping the descending thoracic aorta for elective thoracic aortic aneurysm repair and suggest that the BIS® monitor provides useful information on altered propofol pharmacokinetics after aortic cross-clamping.

Case Report

A 46-yr-old man was admitted for elective thoracic aortic aneurysm repair. His history was unremarkable except for hypertension. After routine monitoring of vital signs was supplemented with BIS® monitoring, anesthesia was induced with fentanyl and propofol and maintained with infusions of propofol and ketamine and intermittent injections of fentanyl via an upper limb vein. The infusion rate of propofol was varied to maintain the BIS between 40 and 60. A Swan-Ganz catheter was inserted into the right internal jugular vein for monitoring continuous cardiac output. The patient had consented to participate in a clinical investigation of the suppressive effects of propofol anesthesia on transcranial electrical motor evoked potentials during thoracic and thoracoabdominal aortic surgery. Blood samples for this purpose were drawn from the arterial line at defined time intervals. A stable level of anesthesia was maintained, with a BIS score of approximately 60. After isolation of both the right femoral artery and vein, the arterial cannula was inserted and then attached to the pump oxygenator. A long venous cannula (Long Cannula RK-28M, Toyobo, Osaka, Japan) was introduced into the right femoral vein, and the tip of this catheter was advanced between the inferior vena cava and right atrium. The tip was confirmed to be correctly positioned by transesophageal echocardiography. A standard roller pump and oxygenator to circulate oxygenated blood from the long venous cannula to the femoral artery were available for partial cardiopulmonary bypass of distal perfusion. During surgery, the patient was hemodynamically stable. A cross-clamp of the descending thoracic aorta at the level of Th 7 was performed, followed by the start of partial cardiopulmonary bypass of distal perfusion at a perfusion rate of 3–3.2 l/min under normothermic conditions. Guided by transesophageal echocardiographic images that revealed the left ventricular cavity size and function, perfusionists could regulate the rate of distal perfusion and level in the venous reservoir for adequate preload in the upper body. Approximately 15 min after cross-clamping, the patient’s BIS level decreased rapidly from its steady-state value of 60 to a value of 0 (infusion rate of propofol, 6 mg · kg⁻¹ · h⁻¹). Mean arterial pressure was 72 mmHg, and continuous cardiac output monitoring indicated 1.2–1.4 l/min proximal to the aortic cross-clamp. Pulsation of bilateral carotid arteries was clearly palpable, suggesting adequate blood supply to the brain. Although depth of anesthesia was assessed as very deep, infusion of propofol was discontinued until the BIS started to increase. Fifteen minutes after infusion of propofol was stopped, the BIS began to increase by degrees. At a BIS score of 30, infusion of propofol was begun at 6 mg · kg⁻¹ · h⁻¹. Subsequently, the BIS score began to decrease again and was less than 10 at approximately 25 min after restart of propofol infusion. This phenomenon could be reproduced by “stopping and restarting” of propofol infusion (Fig. 1). An aortic graft was inserted, with a cross-clamp time of 105 min. Approximately 15 min after declamping, the patient’s BIS level increased slowly from a value of 20 to more than 30. Surgical procedures were completed uneventfully, and this patient was admitted to the intensive care unit, with an anesthetic time of 7 h 45 min. The patient had recovered completely from anesthesia 6 h after admission to the intensive care unit and manifested no neurologic deficits. All blood samples drawn simultaneously from the radial artery and the left femoral artery, including those before cross-clamping of the aorta, at 3 time points during aortic cross-clamping, and 15 min after declamping, were retained for high-performance liquid chromatography (MC Medical, Inc., Osaka, Japan) analysis. High-performance liquid chromatography analysis revealed that the propofol concentrations of samples from the radial artery (proximal to the aortic clamp) during cross-clamping of the aorta were significantly elevated compared with pre-cross-clamping values. Also, propofol concentrations in samples from the radial artery were approximately 4–5 times higher than those from the femoral artery (Fig. 1).

Discussion

The depth of anesthesia using propofol was assessed with the BIS® monitor, which appears to be a very promising tool for evaluating the adequacy of anesthesia. Therefore, the BIS® monitor can provide information on an adequate rate of propofol infusion in individual patients. In our case, before the aortic cross-clamp, the BIS® monitor indicated that 6 mg · kg⁻¹ · h⁻¹ of propofol was an adequate rate of infusion. However,
despite steady infusions of propofol, a rapid decrease in BIS occurred approximately 15 min after the aortic cross-clamp. Hypoperfusion in the brain was an unlikely cause of this decrease, according to physical findings that included palpable pulses of bilateral carotid arteries and hemodynamic variables that included radial arterial blood pressure and cardiac output. Indeed, this patient had normal emergence from anesthesia and normal neurologic function within 24 h of the postoperative period. In this case, BIS values had altered, corresponding to the “stopping-restarting” of propofol infusion, and the plasma propofol concentration was much higher during the aortic cross-clamping than before. It was therefore likely that the increase in plasma propofol concentration (> 7 μg/ml) would induce an isoelectrical encephalogram resulting in a BIS of 0 during the aortic cross-clamp.

There are two explanations for such a decreased BIS value. First, cross-clamping of the thoracic aorta would change circulatory conditions, such as reducing circulating volume and decreasing cardiac output in the area proximal to the aortic cross-clamp, because blood flow from the heart should be only for perfusion of the head, neck, and upper limbs. It was reported that blood flow through the descending thoracic aorta was approximately 65–70% of the cardiac output in humans, meaning that only 30–35% of cardiac output may be essential for perfusion of the area proximal to the cross-clamp of the descending thoracic aorta. Therefore, it would be reasonable for approximately one third of the total blood volume to be circulated in the area proximal to the aortic cross-clamp. In this case, transesophageal echocardiographic images confirmed that the tip of the long venous cannula was positioned at the junction between the inferior vena cava and right atrium. This long venous cannula has 10 oval side-holes (10 × 5 mm) in the 20 cm that compose the tip. We believe that much of the venous blood in the inferior vena cava would be withdrawn from the side-holes of this cannula during the cardiopulmonary bypass. During the stage of cardiopulmonary bypass for distal perfusion, we used transesophageal echocardiography to monitor the left ventricular cavity size and function to allow adequacy of preload and optimal fluid resuscitation for maintenance of both upper and lower body perfusion. Although it is likely that blood from the inferior vena cava should enter the right atrium and mix with blood from the superior vena cava, we think that only a small amount of such blood entered the right atrium, with the result that an almost “split circulation” was produced by the thoracic aortic cross-clamp. This change would greatly reduce the distribution volume of propofol infused via the upper limb and result in much higher plasma propofol concentrations in the body proximal to the aortic cross-clamp when the infusion rate was set on the basis of body weight.

Second, the reduction of hepatic clearance of propofol should be considered. A clinical study of patients having orthotopic liver transplantation showed that the area under the time–blood propofol concentration curve was significantly greater than in patients having extrahepatic abdominal surgery. Furthermore, Mashimo et al. demonstrated that total plasma clearance of propofol in the anhepatic phase was significantly lower than that in the postanhepatic phase during liver transplantation in the pig. Because blood flow into the liver from the area proximal to the aortic cross-clamp theoretically vanishes, propofol clearance is ultimately decreased in that area, which would, in part, result in an increase in the blood concentration of propofol.

In our patient, ketamine, as well as propofol, was infused at 0.5 mg · kg⁻¹ · h⁻¹ during the aortic cross-clamp. Although we did not measure blood concentra-
tions of ketamine in this patient, it is, of course, likely that with the infusion of ketamine, its blood concentration increased and deepened the level of anesthesia. Together with the series of observations in our patient, this dramatic change of BIS values should be associated predominantly with changes in propofol pharmacokinetics.

In our institution, monitoring of motor evoked potentials was used to monitor the functional integrity of the descending motor pathways during thoracic or thoracoabdominal aneurysm surgery under total intravenous anesthesia via an upper limb vein. It has been our experience in surgery of the descending thoracic aorta that motor evoked potentials, in the setting of steady-state propofol infusion, disappeared during the aortic cross-clamp and reappeared after propofol infusion was stopped. From this case and those experiences, it can be considered that in the cross-clamp of the thoracic aorta, a rapid change in BIS value may reflect an increase in propofol concentration in “the brain,” caused by a reduction of distribution volume for propofol and an ultimate reduction of its clearance. This change may induce undetectable motor evoked potentials without any spinal cord injury during thoracic aortic surgery and result in a “false-positive.”

In conclusion, we would like to emphasize that an unexpected, rapid decrease in the BIS score during cross-clamp of the thoracic aorta might reflect an unexpected increase in propofol concentration in the proximal area of the aortic cross-clamp. It was speculated that this increase in propofol concentration might be caused by alterations of the pharmacokinetics of propofol by the aortic cross-clamp. The BIS® monitor is a useful tool for providing information on the adequate infusion rate of propofol during descending thoracic aortic surgery.

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Recording Electrocardiograms Can Be Dangerous

**Jürgen Peters, Prof. Dr. med**

PARTICIPATION of anesthesiologists in murder trials is probably rare. I became involved in a case of an anesthesiologist prosecuted for murder by application of succinylcholine. The case investigated whether electrocardiogram strip chart recordings, showing ventricular fibrillation and presented by the charged physician as being recorded from his wife during cardiopulmonary resuscitation (CPR), were authentic or faked with a simulator.

**Case Report**

A 35-yr-old woman was found dead by a mobile physician and paramedic rescue team at the bottom of a stairway next to a vacuum cleaner. Prolonged CPR was unsuccessful. Eight minutes earlier, the team had been dispatched to the scene, a couple’s home, via telephone alert by the woman’s husband, a trained anesthesiologist. He reportedly had found his wife unconscious and looking pale, with a slow and weak pulse that eventually faded. Before the alert, he himself...
random coincidence, this implied that electrocardiogram tracings stored in and displayed by this particular simulator. Ruling out during CPR, was identical with the unique ventricular fibrillation pattern previously presumed to have been recorded from the accused’s wife part of the electrocardiographic recordings secured on the scene, appeared to be repetitive after 4 s. Accordingly, I testified that at least one recording from the simulator. In fact, both tracings showing ventricular fibrillation secured on the scene bore a striking resemblance they had been originally obtained. Of note, the tracing showing ventricular fibrillation were essentially superimposable when using imaging software (fig. 1). Furthermore, the fibrillation pattern appeared with one recording from the simulator. In fact, both tracings showing ventricular fibrillation were essentially superimposable when using imaging software (fig. 1). Furthermore, the fibrillation pattern appeared to be repetitive after 4 s. Accordingly, I testified that at least part of the electrocardiographic recordings secured on the scene, previously presumed to have been recorded from the accused’s wife during CPR, was identical with the unique ventricular fibrillation pattern stored in and displayed by this particular simulator. Ruling out random coincidence, this implied that electrocardiogram tracings seized on the scene had not been recorded from the woman found dead.

Subsequently, the anesthesiologist admitted to having killed his wife, without elaborating on the circumstances for legal reasons, and was sentenced to prolonged imprisonment.

**Discussion**

This case is interesting from a medical, educational, and legal perspective. Certainly, intravenous or intramuscular succinylcholine can evoke prolonged respiratory muscle paralysis and asphyxia within minutes. However, because it is rapidly cleaved in blood and tissues and breakdown continues after death, succinylcholine can hardly be detected in specimens by routine forensic mass spectrometry. Accordingly, succinylcholine was not detected in the remains of five victims of a confessed serial killer using intramuscular suxamethonium, but was detected in a syringe buried nearby. With no proof of succinylcholine administration, the prosecutor’s line of evidence rested on the investigation of whether electrocardiographic recordings, previously stated by the accused to have been recorded personally from his wife during CPR, were faked, thus implying a criminal act.

Ventricular fibrillation is recognized by erratic activity around the electrocardiogram’s baseline with no regular pattern, but possible periodicity has not been studied in humans. However, fibrillated animal hearts show little evidence of relevant periodicity. Thus, any repetitive pattern during an epoch of apparent fibrillation suggests artifact rather than authentic cardiac activity.

Electrocardiogram simulators have stored in their memory epochs of rhythms once recorded from “real” patients. It is less appreciated, however, that these epochs are displayed as endless loops and, hence, display periodicity not present in original recordings. With respect to ventricular fibrillation, this simulator displays an identical fibrillation pattern every 4 s (fig. 1). Accord-

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Fig. 1. Ventricular fibrillation tracing recorded from a simulator, the tracing presented to the rescue team, and both tracings superimposed using imaging software. Epochs from the simulator are repeated after 4 s (arrows).
Successful Resuscitation from Prolonged Ventricular Fibrillation Using a Portable Percutaneous Cardiopulmonary Support System

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TWO cases of ventricular fibrillation (VF) under general anesthesia during noncardiac surgery were presented. Although both patients were refractory to conventional cardiopulmonary resuscitation (CPR), they were rescued using a percutaneous cardiopulmonary support (PCPS) system without any complications. We emphasize the importance of emergency extracorporeal circulation.

A 75-yr-old man was scheduled for gastrectomy under general anesthesia with a diagnosis of early gastric cancer. He had had dilated cardiomyopathy for 5 yr. His medications included an angiotensin-converting enzyme inhibitor, digitalis, and a β-blocker. His physical status was New York Heart Association class II. Preoperative echocardiography revealed mild mitral regurgitation and diffuse left ventricular hypokinesis with an ejection fraction of 34%. Coronary angiography performed 1 month earlier showed mild luminal irregularities in the right and left coronary arteries but no significant stenotic changes.

Anesthesia was induced with midazolam, fentanyl, and vecuronium, and the trachea was intubated. Anesthesia was maintained with sevoflurane–oxygen and nitrous oxide. Radial artery and pulmonary artery catheters were inserted, and their pressures were 120/80 mmHg with PCPS as a life-saving measure in prolonged CPR during intraoperative cardiac arrest.

Case Reports

**Case 1**

and 25/12 mmHg, respectively. Ten milliliters 1% lidocaine was administered through an epidural catheter inserted from Th8 to Th9, followed by continuous infusion at a rate of 4 ml/h of a mixture of 40 ml 1% lidocaine and 500 µg fentanyl.

The surgery proceeded uneventfully with stable hemodynamics and arterial oxygen saturation. When the epigastric artery was ligated 1 h after the surgery was begun, however, VF occurred after ventricular extrasystoles. Closed-chest compression was immediately started by the surgeons, sevoflurane was switched off, and the lungs were manually ventilated with oxygen. For resuscitation, 1.0 mg ephedrine, 3.0 mg epinephrine in total, 80 mg lidocaine, and 20 ml sodium bicarbonate were administered. The findings of arterial blood gas/pH and electrolyte analysis during CPR revealed pH 7.41, 29 mmEq/l pCO2, 477 mmHg po2, 131 mEq/l Na, and 4.3 mEq/l K, with a hematocrit of 38%. A peak arterial pressure of 80 mmHg was maintained by closed-chest compression during CPR. The patient could not be defibrillated with direct current shocks despite six attempts (200 J, 300 J, 400 J × 2). The decision to use PCPS was made 25 min after the onset of VF. A 16.5-French, 15-cm perfusion cannula (CX-EB16ASH, TERUMO, Tokyo, Japan) was inserted through the left femoral artery, and a 21-French, 50-cm draining cannula (CX-EB21VSH, TERUMO) was inserted in the right atrium through the right femoral jugular vein. Placement of perfusion and draining cannulae was performed using a modified Seldinger technique as follows. After skin preparation and draping, we advanced an 18-gauge needle into the vessels, replaced it with a guidewire, and incised the skin. The percutaneous tract was

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thin arrows 
later, ventricular fibrillation developed. 

Arterial pressure decreased suddenly to 50/25 mmHg. ST segment elevation in electrocardiogram lead II before VF developed. The patient was hemodynamically stable except for short runs of ventricular extrasystole observed when the surgery was started. This was treated with intravenous 125 mg mexiletine hydrochloride.

When the pancreatectomy was almost completed with 200 ml blood loss 3 h after the start of the surgery, VF developed shortly after hypotension (fig. 2B and C). Resuscitative measures were promptly started, and the lungs were ventilated with pure oxygen. Direct current shocks (200 J, 300 J, 360 J × 3) along with administration of drugs, including 50 mg lidocaine, 5.5 mg epinephrine in total, and 40 U vasopressin, were ineffective for restoring spontaneous heart rhythm. VF persisted despite CPR. We decided to use PCPS 20 min after the onset of VF. Emergency extracorporeal circulation was established percutaneously through cannulae inserted into the femoral vein and artery 10 min after that. We stopped chest compression and administration of drugs for resuscitation on initiation of extracorporeal circulation. Although a high mean arterial pressure was achieved initially because of the residual vasoconstrictive effect, it could be maintained at a flow rate of 3 l/min with a mean arterial pressure of 80 mmHg 20 min later. Direct current shock immediately after extracorporeal circulation failed, but the patient was defibrillated on PCPS 20 min later and spontaneous circulation was restored. The flow rate was reduced to 2.0 l/min, and sevoflurane inhalation was restarted. Twenty milligrams heparin was administered for anticoagulation at 1 h after extracorporeal circulation. The automatic clotting time was maintained around 200 s after that. The surgery was completed 4 h later. Coronary angiography performed on the same day as PCPS revealed mild stenosis in the left anterior descending coronary artery. This was interpreted as insignificant by cardiologists. The patient was successfully decannulated the next day in the intensive care unit and transferred to the ward the following day. He was able to return home 2 weeks later without any neurologic complications.

Discussion

We experienced two successful CPRs using PCPS in patients with refractory VF during noncardiac surgery. In our patients, conventional CPR was continued for about 35 min and 30 min in cases 1 and 2, respectively. The time required to initiate cardiopulmonary support after a decision to do so was made was 10 min. We believe that the two patients would not have fully recovered without the use of PCPS.

In 1989, Long et al.\(^1\) reported a case of successful resuscitation of bupivacaine-induced cardiac arrest using a conventional cardiopulmonary bypass machine. They needed a midsternotomy for total extracorporeal circulation, blood transfusion to increase hematocrit, and volume infusion to increase mean arterial pressure. The

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**Fig. 2.** (A) Playback of the electrocardiogram II lead and arterial pressure tracing at a paper speed of 25 mm/s from case 2 after induction of anesthesia (arterial pressure = 125/51 mmHg). (B) Arterial pressure decreased suddenly to 50/25 mmHg. ST segment elevation and short run are noted. (C) Thirty seconds later, ventricular fibrillation developed.
complexity and technical difficulty of the procedure prevented its widespread use as a resuscitative measure. With the advent of the PCPS system composed of a centrifugal pump and heparin-bonded preconnected circuitry with a hollow fiber membrane, extracorporeal circulation became more practical.

Extracorporeal circulation with PCPS is a well-established clinical technique in high-risk cardiac catheterization and postcardiotomy cardiogenic shock. Recently, anecdotal case reports have suggested increased recognition of emergency PCPS as a life-saving measure for pulmonary thrombosis, cardiac failure with pulmonary hypertension, in-hospital CPR, and drug intoxication. Nevertheless, statistics regarding the use of emergency PCPS have revealed that the results are not necessary favorable, especially when the neurologic outcome is considered as the end point. Implementation of PCPS more than 30 min after unwitnessed cardiac arrest or CPR yields a patient survival rate of less than 10%. The decision to use PCPS should be made as soon as possible in prolonged CPR for complete recovery.

To the best of our knowledge, no cases of emergent PCPS resuscitation in patients with noncardiac surgery have been previously reported. Because cardiac arrests during general anesthesia are all witnessed, victims in the operating room seem to benefit most from PCPS. A reported good survival rate for cardiac arrest victims in a catheterization laboratory, where situations are similar to those observed in the operating room with the use of PCPS, confirms this speculation.

Technical advances such as preassembled circuitry, a small prime volume of 470 ml, a centrifugal pump, ease of air clearance from circuitry because of the absence of the heat exchanger and autoprime functions of the system, and a percutaneous technique with thin-walled cannulae made the rapid initiation of extracorporeal circulation feasible (fig. 1). Because the heating pad incorporated into the PCPS is not so effective as a heat exchanger for the control of body temperature, patients become slightly hypothermic at 33–35°C during the course of extracorporeal circulation with our PCPS. Because hypothermia has neuroprotective effects, however, the unavoidable hypothermia might have contributed to the complete recovery of our patients to some extent.

Although PCPS seems to be life saving in many cases of prolonged CPR in the operating room, it is not indicated for patients with active bleeding or severe aortic regurgitation. The potential complications of PCPS include perforation or injury of vessels during placement of the large cannulae and ischemia in the lower extremities because of compromised blood flow in the femoral artery by the perfusion cannulae. It should be emphasized that for immediate and safe institution of extracorporeal circulation, teamwork on the part of the specialists in the operating room (e.g., anesthesiologists, cardiologists, perfusionists, surgeons) is imperative along with a rapidly available PCPS system.

The increase in coronary perfusion pressure with PCPS may play a pivotal role in the return of spontaneous circulation, because adequate coronary perfusion pressure is well known to be the best predictor of successful defibrillation. In our cases, mean aortic pressures to 130 mmHg (case 1) or 80 mmHg (case 2) were achieved with the institution of PCPS. Right atrial pressure presumably decreased because of venous drainage to PCPS, leading to a substantial increase in the coronary perfusion pressure. The successful defibrillation in our cases may thus be explained by the increased coronary perfusion pressure induced by PCPS.

In summary, we have described two patients with intraoperative cardiac arrest who were successfully resuscitated using a PCPS system. The patients could not have survived without it. Because intraoperative cardiac arrest victims are considered good candidates for full recovery, PCPS should be considered in any difficult cases of CPR in the operating room.

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References

Neuropathy following Axillary Brachial Plexus Block: Is It the Tourniquet?

Case Report

A 65-yr-old woman, American Society of Anesthesiology (ASA) physical class II, presented for open reduction and internal fixation of comminuted and displaced spiral fractures of her left third and fourth metacarpals. Relevant medical history included essential hypertension, which was controlled on hydrochlorothiazide. Bilateral carpal tunnel syndrome had been diagnosed clinically and confirmed by nerve conduction studies 17 yr before presentation. Her symptoms had resolved without surgery. The physical examination was, apart from the fractures, unremarkable. Her blood pressure was 130/60 mmHg, and her heart rate was 74 beats/min in sinus rhythm.

After intravenous administration of 1 mg midazolam and 50 μg fentanyl, an axillary brachial plexus block was performed via the elicitation of paresthesia technique using a 25-gauge, 2-in needle. Ulnar nerve paresthesia was obtained on the first pass, and 35 ml 1.25% mepivacaine and 1:200,000 epinephrine mixture was deposited. On the second pass, radial paresthesia was obtained and 15 ml was deposited. An additional 10 ml local anesthetic was deposited anterior to the axillary artery. A total of 60 ml 1.25% mepivacaine with 1:200,000 epinephrine was deposited into the brachial plexus sheath. There was no pain during injection of the local anesthetic. The intercostobrachial and musculocutaneous nerves were blocked via subcutaneous injection of 5 ml and 7 ml 2% lidocaine at the axilla and antecubital fossa, respectively.

The patient’s left arm was abducted at no more than 90° to the torso and positioned level on an arm table. A tourniquet (Zimmer ATS 2000; Zimmer, Dover, OH) was applied to the midpoint of the left upper arm and inflated to 300 mmHg. The block was satisfactory for the procedure in that neither supplemental nerve block, excessive sedation, nor general anesthesia was required. The patient underwent open reduction and internal fixation of the fractures. After 59 min, the tourniquet was deflated and a loose bulky dressing was applied. With the block still intact, the patient was dismissed to the outpatient area and, subsequently, home.

On the following day, surgical evaluation noted that there was “persistence of total ulnar paresthesia…now almost 24 h after the block.” These symptoms persisted after the dressing was loosened. Three weeks later, the patient had “ulnar aching and dyesthesias up the forearm, and occasional shocks and discomfort on abduction of the arm.” Surgical opinion was that the neurologic deficit was not caused by operative trauma but by injury resulting from the axillary block.

Three weeks after surgery, a neurologic consultation was obtained; examination revealed decreased hypothenar and interosseous strength, decreased ulnar digit flexion, and decreased light touch and pinprick sensation on the left. At the time of the consultation, nerve conduction and electromyographic studies were obtained (Tables 1 and 2). Nerves were stimulated at the elbow and wrist, and responses were recorded in the hand. The amplitudes of the left ulnar and radial sensory and median motor responses were reduced. Motor and sensory distal latencies, conduction velocities, and F-wave latency were normal. Needle electrode examination of the muscles on the left demonstrated fibrillation potentials in all muscles sampled below the elbow and in the biceps above the elbow, consistent with a polyneuropathy. Voluntary motor unit potentials were normal throughout. The results indicated partial axonal degeneration of the ulnar, median, radial, and musculocutaneous nerves below the level of the tourniquet in the midupper arm. (There was also evidence of a mild bilateral median neuropathy at the wrists, consistent with her previous nerve conduction studies.) By 6 months, her symptoms had completely resolved.

Discussion

The tourniquet is used in peripheral limb surgery to produce a bloodless surgical field. Post-tourniquet nerve palsy or “tourniquet paralysis” is well documented, and the incidence of tourniquet paralysis has been reported as 1 in 8,000 operations.5 Recommendations for appropriate use of the tourniquet include the maintenance of a pressure no more than 150 mmHg greater than the systolic blood pressure and deflation of the tourniquet every 90–120 min.6 Even the modern-day tourniquet used according to these recommendations may result in tourniquet paralysis, however.7 A recent prospective observational study of upper and lower limb blockade using a nerve stimulator and the multiple injection technique demonstrated that higher tourniquet inflation pressure (> 400 mmHg) was associated with an increased risk of transient nerve injury.8 Prolonged tourniquet time is also associated with an increased incidence
In uremic patients. Similar reports appeared subsequent- 

**CASE REPORTS**

L, deltoid Normal 0 Normal

R, flexor digitorum profundus Normal 0 Normal

L, abductor digiti minimi Increased +++

R, flexor carpi radialis Increased ++++

L, biceps brachii Increased ++

R, brachioradialis Increased ++

L, deltoid Normal 0 Normal

Table 2. Electromyographic Studies

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<th>Fibrillation Potentials</th>
<th>Voluntary Motor Unit Potentials</th>
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<td>Normal</td>
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<tr>
<td>R, flexor carpi radialis</td>
<td>Normal</td>
<td>0</td>
<td>Normal</td>
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<td>L, abductor digiti minimi</td>
<td>Increased</td>
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<tr>
<td>L, biceps brachii</td>
<td>Increased</td>
<td>++</td>
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<td>L, brachioradialis</td>
<td>Increased</td>
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<td>L, deltoid</td>
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<td>L, extensor indicis</td>
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<td>L, first dorsal interosseous</td>
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<tr>
<td>L, triceps</td>
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</table>

Note the normal voluntary motor unit potentials and the distal left fibrillation potentials and increased insertion activity.

L = left; R = right.

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plexus injuries account for 28% and 20%, respectively. Caplan\(^\text{20}\) notes that only 9% of medicolegal cases of perioperative neuropathy have a recognizable cause despite extensive investigation. In a retrospective study of patients at high risk for neuropathy undergoing upper extremity surgery under axillary block, Horlocker et al.\(^\text{4}\) determined that 11.3% of nerve injuries were anesthesia related and 88.7% were surgery related. Only clinical criteria (i.e., level and distribution of the neuropathy) were used to differentiate anesthesia-related nerve injury from surgery-related nerve injury, however.

Mechanical pressure on nerve tissue has long been recognized in the pathogenesis of tourniquet paralysis. Our report illustrates that interruption of the blood supply, as occurs in IMN, may also play a role. When presented with neuropathy after upper limb surgery under axillary brachial plexus block, the anesthesiologist needs to consider all risk factors, including the tourniquet, in the differential diagnosis of the neuropathy. Importantly, electrophysiology studies, as illustrated in our case report, will determine the site and mechanism of the injury as well as the prognosis for recovery.

References