A prospective, randomised, controlled clinical trial to evaluate the effect of nitrous oxide on propofol requirement in elective craniotomy in which entropy was used to measure depth of anaesthesia

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Introduction

The maintenance of a strict cerebral physiological balance and early recovery for neurological assessment is required for neurosurgical anaesthesia. Propofol is a standard induction, as well as a maintenance agent, owing to its favourable effects on neurophysiology. It causes a dose-dependent decrease in intracranial pressure (ICP), while maintaining cerebral perfusion pressure at a modest dose, and also decreases the cerebral metabolic rate of oxygen. Furthermore, propofol total intravenous anaesthesia results in a clinically relevant reduction in postoperative nausea and vomiting (PONV). However, the potentially higher cost is a concern.

Nitrous oxide (N₂O) is used widely in neuroanaesthetic practice as it produces amnesia, analgesia and haemodynamic stability. It also enables rapid recovery. It has been shown in clinical trials to reduce the dose requirement of other anaesthetic agents. N₂O reduces the cost of intravenous anaesthesia. We hypothesised that the drug-sparing effect of N₂O should reflect on the maintenance dose requirement of propofol. Still, certain controversies surround the role of N₂O in neuroanaesthesia owing to its unfavourable effects on neurophysiology, and other side-effects, such as tension pneumoencephalus, nausea and vomiting, a neurological deficit in vitamin B₁₂-deficient patients and increased wound infections. A randomised study was conducted to determine the dose requirement of propofol when used with and without N₂O in patients undergoing an elective craniotomy, in which entropy was used to measure depth of anaesthesia. The surgical conditions were also observed, and the haemodynamic profile and recovery characteristics compared, with and without N₂O, in the two groups. The primary aim of our study was to evaluate the effect of N₂O on propofol dose requirement. The secondary aim was to evaluate the safety profile of N₂O in neuroanaesthesia.

Method

After obtaining approval from the hospital ethics committee and receiving the informed consent of the patients, 50 American Society of Anesthesiologists (ASA) physical status grade I/II patients, of either gender, aged 18–60 years, and scheduled for elective craniotomies for supratentorial tumours, were included in the study. Patients who were pregnant, drowsy, likely to require postoperative mechanical ventilation, who had evidence of major cardiopulmonary, hepatic or renal disease, and those with a known allergy to the study drugs, were excluded from the study.

Patients were kept fasting for six hours and premedicated with oral alprazolam 0.5 mg at bedtime, and two hours before surgery.

Monitoring included:
- Noninvasive blood pressure.
- An electrocardiogram.
- Heart rate.
- Pulse oximetry.
- Response entropy (RE).
- State entropy (SE) (with M-Entropy S/STM Module® (GE Healthcare)) using a sensor attached to the forehead of the patient.
- Capnography (end-tidal carbon dioxide (ETCO₂)).
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The patients were randomised into two groups using a random digit table. Group A (the N₂O group) received a N₂O, oxygen and propofol infusion, and Group B (the propofol group) received an air, oxygen and propofol infusion. A similar type and size of supratentorial tumour resection, mostly meningiomas or gliomas, were operated on in both the groups. Baseline systolic blood pressure (SBP), diastolic blood pressure (DBP), mean blood pressure (MBP), heart rate (HR), SE and RE were recorded. The patient’s lungs were preoxygenated for three minutes. Fentanyl 2 μg/kg intravenously was administered, followed by propofol 2 mg/kg and atracurium 0.5 mg/kg, to facilitate tracheal intubation with a flexible metallic tube. The propofol infusion was started at a rate of 50 μg/kg/minute simultaneously with induction, keeping the entropy value ≤ 40 until tracheal intubation, and between 40 and 60 intraoperatively. During induction and maintenance, the lungs were ventilated using 67% N₂O in oxygen in group A, and 33% oxygen in air in group B, maintaining a fraction of inspired oxygen of 33%. Fentanyl (2 μg/kg/hour) and atracurium (10 μg/kg/minute) infusions were started.

The intraoperative entropy score was maintained between 40 and 60, CVP between 5 cmH₂O and 8 cmH₂O, EtCO₂ between 28 mmHg and 32 mmHg, and nasopharyngeal temperature between 36 °C and 37 °C. Normal saline was used as an intravenous fluid to maintain the CVP. Mannitol (1 g/kg) was administered over 20 minutes, starting at the time of skin incision in all patients. Brain condition was assessed by the operating surgeon (who was unaware of the group allocation of the patient) after opening the cranial cavity as tense (swollen and bulging), reasonable (minimal swelling and acceptable) or ideal (no swelling and excellent). Hypotension, a fall in MBP to less than 20% of baseline or MBP ≤ 65 mmHg, was treated with dopamine 2 μg/kg intravenously was administered, followed by propofol 2 mg/kg and atracurium 0.5 mg/kg, to facilitate tracheal intubation with a flexible metallic tube. The propofol infusion was started at a rate of 50 μg/kg/minute simultaneously with induction, keeping the entropy value ≤ 40 until tracheal intubation, and between 40 and 60 intraoperatively. During induction and maintenance, the lungs were ventilated using 67% N₂O in oxygen in group A, and 33% oxygen in air in group B, maintaining a fraction of inspired oxygen of 33%. Fentanyl (2 μg/kg/hour) and atracurium (10 μg/kg/minute) infusions were started.

The trachea was extubated following the return of adequate spontaneous respiration, protective reflexes and an entropy score > 70. Heart rate, MBP, SBP and DBP, entropy values (RE and SE), EtCO₂, and inspiratory and expiratory N₂O concentrations were recorded at baseline, post induction, post intubation and every five minutes thereafter intraoperatively.

Time to eye opening after the cessation of propofol was noted. Recovery characteristics were recorded as a modified Aldrete score at 10 minutes and 30 minutes postoperatively.

Patients were transferred to the neurointensive care unit (NICU), when the modified Aldrete score was ≥ 8. Adverse effects, such as nausea and vomiting, or episodes of haemodynamic instability, were recorded for six hours in the NICU. Patients were questioned 24 hours after surgery about what they remembered last, and if they had any memories of the surgery.

The sample size was calculated using data from a previous study.12 A sample size of 50 patients was required to achieve a 33% reduction in effective concentration 50 (EC50) of propofol with 67% N₂O, with a power of 80% and α of 0.05. Statistical analysis was performed using Windows® SPSS® version 12.0. The data are presented as continuous variables in terms of mean and standard deviation (MBP, DBP, SBP and propofol infusion rate and time to eye opening), and as categorical variables in terms of percentage (sex and ASA grade). Student’s t-test was used for the continuous data after normal distribution of the continuous variables validated by the Kolmogorov-Smirnov one-sample test, and for catagorical data chi square test and Fischer’s exact test were used. A p-value of ≤ 0.050 was taken to be the level of statistical significance.

Results

The two groups were comparable in terms of age, weight, sex distribution, ASA grade and duration of anaesthesia (p > 0.050) (Table 1).

The mean dose requirement of propofol during maintenance was significantly higher (47%) in the propofol group (102.30 ± 14.00 μg/kg/minute) compared with the N₂O group (54.30 ± 11.47 μg/kg/minute) (Table 1).

The intergroup comparison of mean HR at different time intervals is shown in Figure 1. The baseline mean HR was comparable between the two groups (p = 0.967). The mean HR was significantly lower in group A (the N₂O group) compared to that in group B (the propofol group) after five minutes of intubation (71.76 ± 13.91 μg/kg/minute vs. 82.56 ± 14.08 μg/kg/minute, respectively) (p = 0.009). Thereafter, the HR was comparable in both the groups (p-value ≥ 0.050).

Table 1: Demographic data, duration of anaesthesia and propofol dose requirement

<table>
<thead>
<tr>
<th>Demographic data</th>
<th>Group A (N₂O group)</th>
<th>Group B (propofol group)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>48.00 ± 13.30</td>
<td>46.20 ± 10.70</td>
<td>0.609</td>
</tr>
<tr>
<td>Weight (kg)</td>
<td>63.40 ± 10.60</td>
<td>60.20 ± 7.20</td>
<td>0.268</td>
</tr>
<tr>
<td>Sex (male and female) (n, %)</td>
<td>16 (64):9 (36)</td>
<td>14 (56):11 (44)</td>
<td>0.564</td>
</tr>
<tr>
<td>ASA grade (I and II) (n, %)</td>
<td>12 (48):13 (52)</td>
<td>10 (40):15 (60)</td>
<td>0.569</td>
</tr>
<tr>
<td>Duration of anaesthesia (minutes)</td>
<td>161.60 ± 31.10</td>
<td>157.60 ± 31.00</td>
<td>0.651</td>
</tr>
<tr>
<td>Propofol dose (μg/kg/minute)</td>
<td>54.30 ± 11.47</td>
<td>102.30 ± 14.00</td>
<td>&lt; 0.001</td>
</tr>
</tbody>
</table>

Note: ASA: American Society of Anesthesiologists; N₂O: nitrous oxide.
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The baseline mean blood pressure (MBP) was comparable in the two groups (p = 0.573). A statistically significant lower MBP was observed in group A at post induction, and at five minutes post intubation, compared with that in group B. A higher MBP was observed in group B (the propofol group) compared with that in group A (the N2O group), at several time points, for which an increase in the propofol infusion rate was required (Figure 2).

There were no intraoperative or postoperative complications, i.e. pneumoencephalus, PONV, respiratory depression or the need for postoperative ventilatory support, in either group. None of the patients in either group reported being aware of intraoperative events when questioned 24 hours postoperatively.

Discussion

The results of our study indicate that when N2O was used with the propofol infusion for the maintenance of anaesthesia, the propofol dose requirement was significantly less compared to the propofol infusion alone requirement in patients undergoing supratentorial surgery. We found in our study that the maintenance dose of propofol was 54.30 ± 11.47 µg/kg/minute, and 102.30 ± 14.00 µg/kg/minute, with and without N2O, respectively. Thus, the propofol requirement was considerably lower when used together with N2O. Davidson et al. reported that the addition of 67% N2O reduced the EC50 of propofol by 33%. Similarly, Dube et al. also found that the maintenance dose of propofol, with and without N2O, was 71.26 ± 11.78 µg/kg/minute and 90.82 ± 19.13 µg/kg/minute, respectively. Hemelrijck et al. reported that the electroencephalography (EEG)-titrated propofol requirement was significantly less when used with N2O, when compared with the use of propofol alone (123 ± 5.27 µg/kg/minute vs. 150 ± 2.77 µg/kg/minute, or 7.4 ± 1.9 mg/kg/hour vs. 9.0 ± 1.0 mg/kg/hour). Singh et al. also reported that there was an increased consumption of opioids and muscle relaxants in the N2O-free group of patients undergoing supratentorial tumour surgery. This emphasises the analgesic potency of N2O. Ng and Hwang found that the co-administration of N2O during the induction of anaesthesia reduced the induction dose requirement of propofol.

A propofol requirement of 100-200 µg/kg/minute, together with N2O and an opioid analgesic in orthopaedic surgery, Caesarean section and other surgery, has been demonstrated in previous

Table 2: Recovery characteristics of the study participants

<table>
<thead>
<tr>
<th>Time (minutes)</th>
<th>Group A (N2O group)</th>
<th>Group B (propofol group)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time to eye opening (minutes)</td>
<td>2.51 ± 1.03</td>
<td>8.54 ± 8.15</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Aldrete score at 10 minutes</td>
<td>9.24 ± 0.77</td>
<td>7.88 ± 1.61</td>
<td>0.001</td>
</tr>
<tr>
<td>Aldrete score at 30 minutes</td>
<td>10.00 ± 0.00</td>
<td>9.84 ± 0.37</td>
<td>0.039</td>
</tr>
</tbody>
</table>

Table 3: Intraoperative brain status of the study participants

<table>
<thead>
<tr>
<th>Brain status</th>
<th>Group A (N2O group)*</th>
<th>Group B (propofol group)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tense (swollen and bulging)</td>
<td>1 (4)</td>
<td>0 (0)</td>
<td>0.600</td>
</tr>
<tr>
<td>Reasonable (minimal swelling and acceptable)</td>
<td>23 (92)</td>
<td>24 (96)</td>
<td></td>
</tr>
<tr>
<td>Ideal (no swelling and excellent)</td>
<td>1 (4)</td>
<td>1 (4)</td>
<td></td>
</tr>
</tbody>
</table>

Table note: N2O: nitrous oxide.
*Values are expressed as mean ± standard deviation.
* A difference was not found in the intraoperative condition of the brain in both groups (p = 0.600) (Table 3).

The baseline MBP was comparable in the two groups (p = 0.573). A statistically significant lower MBP was observed in group A at post induction, and at five minutes post intubation, compared with that in group B. A higher MBP was observed in group B (the propofol group) compared with that in group A (the N2O group),
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It is widely appreciated that N₂O decreases the incidence of awareness. Although this observation has been questioned by certain investigators. Entropy has now been established as a useful monitor with which to assess the depth of anaesthesia in patients undergoing supratentorial neurosurgical procedures. We maintained the entropy value between 40 to 60 during the maintenance phase, as recommended by Vakkuri et al. Anderson and Jakobsson found that loss of consciousness with N₂O was not associated with a change in the entropy index. In contrast, Hans reported that the addition of N₂O during balanced anaesthesia provoked a decrease in the RE and SE of EEG. Dube et al. also observed a significantly higher bispectral index value in the propofol group than that in the N₂O group.

The Aldrete score at 10 minutes of cessation of the propofol infusion revealed that recovery was significantly faster in the N₂O group compared to that in the propofol group. This is probably because of the significantly higher dose of propofol required by patients in the propofol group. The Aldrete score at 30 minutes was statistically significantly different between the two groups, although the difference was not clinically significant.

The surgical conditions assessed by the surgeon were comparable in the two groups. Hemelrijck et al. also reported that the surgical conditions (brain relaxation) were similar in the two groups.

PONV is unacceptable following neurosurgical procedures. N₂O has been implicated in causing PONV. However, none of the patients in our study experienced nausea or vomiting. This could be owing to the antiemetic action of propofol. Although N₂O has been implicated in complications, such as raised ICP and pneumoencephalus, these were not observed in our study. Singh et al. also found that using N₂O in patients undergoing supratentorial craniotomies did not prolong the duration of intensive care unit or hospital stay.

The unfavourable effects of N₂O on neurophysiology, such as an increase in the cerebral metabolic rate, cerebral blood flow and ICP, have caused its role in neuroanaesthesia to be debated. To an extent, these effects of N₂O are masked by the concomitant use of propofol. The impact of these unfavourable effects of N₂O were not found in our study on awake (albeit with a small rise in ICP) patients. Since patients with significantly raised ICP, or who were drowsy, were not included in our study, the results cannot be extrapolated to such patients.

Conclusion
We conclude that the use of supplemental N₂O significantly decreased the propofol infusion rate requirement, compared with a propofol infusion alone, in ASA I and II awake patients undergoing supratentorial craniotomies.

References

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