2009 in Review

Advancing Medicine in Anesthesiology

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WELCOME to another year in review, highlighting articles that the Editorial Board believed exemplified the mission of ANESTHESIOLOGY, “to advance the science and practice of perioperative, critical care, and pain medicine through the promotion of seminal discovery.” This year we chose 12 articles with an equal distribution in the three current sections of original investigations: Perioperative Medicine, Critical Care Medicine, and Pain Medicine. In most cases, these 12 articles have already been highlighted through editorials, cover art, press releases, or placement on the home page of the Journal’s Web site. We hope that a brief synopsis at the end of each year is useful for you, either to remember you of important work published this year or to encourage you to look at them for the first time.


This study analyzed the Nationwide Inpatient Sample database and estimated that acute ischemic stroke occurs in 0.7, 0.6, and 0.2% in patients undergoing hemicolectomy, lobectomy/segmental lung resection, and total hip replacement, respectively, with increasing risk with advanced age after each of these procedures (fig. 1). This study is important and interesting in many respects. First, it draws attention to a severe complication responsible for premature death, handicap, and loss of autonomy in elderly patients. Moreover, the incidence of acute ischemic stroke reported here is greater than that usually perceived by the anesthesiology community caring for these patients. Second, it emphasizes the need for us to extend our vision beyond the operating room, a topic of an editorial series in 2009. Third, this study exemplified the use of a very large administrative database to address patient safety issues in real-world conditions. Last, we are caring for more and more elderly people, and the 0.2% incidence of acute ischemic stroke during total hip replacement in this study emphasizes the frailty of these aged patients, although age is clearly not the only important variable.


As anesthesiologists, we interact with patients and their families for a brief but intense period of time, needing to rapidly and effectively communicate much information to each other and to understand each others’ needs and limitations. This article describes an educational program for anesthesia trainees and uses narrative research methods to identify key challenges they face in the informed consent portion of this intense interaction. The results are, on the surface, not surprising to trainees or their teachers: mistrust, misunderstanding, information overload, and conflicts between patient and family wishes and medical judgment. The authors were struck with the amount of angst reported by these trainees but reflected that each of us has experienced and continues to experience such ethical, practical, and relational challenges in our practice. High-fidelity simulation may help us to respond quicker and better to rapidly changing problems in the operating room or to facilitate our learning of procedures. This article suggests that we have important educational opportunities to improve the communication between patients and trainees as they evolve into mature physicians.

Alkire MT, Asher CD, Franciscus AM, Hahn EI: Thalamic microinfusion of antibody to a voltage-
gated potassium channel restores consciousness during anesthesia. Anesthesiology 2009; 110:766–73

Our understanding of neurologic mechanisms involved in anesthetic-induced unconsciousness has made substantial progress over the past years, with recent evidence suggesting a primary cortical site for anesthesia. The thalamus represents the primary relay station for ascending sensory information and descending motor output from the brain, and these authors previously showed that cholinergic stimulation just to the central medial nucleus of the thalamus reversed sevoflurane-induced loss of righting reflex in both receptor- and site-specific manners. They concluded that thalamic acetylcholine receptors regulate the “on switch” controlling arousal, and that anesthetics, by blocking this switch, cause unconsciousness.

In this study, Alkire et al. present additional evidence that thalamic structures are involved in producing anesthesia. Because nicotine is also known to block a variety of potassium channels, Alkire et al. hypothesized that anesthetic-induced unconsciousness might be related to a block of a subset of potassium channels (Kv1.2 channels) in the central medial thalamus. Rats were exposed to either desflurane or sevoflurane, and a Kv1.2 antibody was administered to the central medial thalamus via a microinfusion through an indwelling cannula. No effect was seen in 30% of animals, partial arousal was seen in 13.4%, and full return to consciousness was seen in 16.5%. This study shows that when the potassium channel antibody was infused very close to the medial thalamic nucleus, it induced a transient level of consciousness with restored mobility during desflurane or sevoflurane anesthesia (fig. 2). The arousal response was seen in 75% of animals when the needle tip was located within the central medial thalamus. These findings support the view that this subcortical area is an important relay station for regulation of anesthetic-induced unconsciousness and/or arousal phenomena, and that voltage-gated potassium channels are involved in mediating effects of volatile anesthetics producing unconsciousness in vivo. The results of this exciting investigation can be taken as one step further in the search for structures and
mechanisms controlling anesthesia and may be used as a background for further work to identify primary targets for anesthetic-induced unconsciousness.


The growing popularity for the application of regional anesthesia has led to a wider use of continuous infusion of local anesthetics through perineural catheters to improve postoperative pain management. Initially these techniques were applied specifically to adults, then to children, and more recently to newborns. Complications associated with the application of local anesthetics, including myotoxicity, have been observed in adults. However, whether the severity and the long-term consequence of this toxicity are, as compared with adults, similar, less, or worse in very young children is unknown. This question has been investigated by Nouette-Gaulain et al. A group of young (3-week-old) and adult (12-week-old) rats were randomly assigned to receive seven injections of either 0.25% bupivacaine or isotonic saline during an 8-h period. The authors found that bupivacaine caused both a decrease in mitochondrial adenosine triphosphate synthesis rate and ultrastructural damage in rat muscles. This is per se not new, but the finding that young rats showed an age-dependent impairment of mitochondrial bioenergetics and a significant increase in myofibrillar disruption and z-line streaming is new and worrisome. Although local anesthetic myotoxicity does not seem to be clinically relevant in adults outside of ophthalmology, this study raises concern regarding the application of these techniques in very young children. It is hoped that this study will prompt clinical investigation to determine whether continuous application of local anesthetics is safe in our very young patients.


In the early 1980s, reports emerged from laboratories that acute central nervous system injury is dramatically augmented by hyperglycemia. This is true in numerous species. The anesthesiology community rapidly assimilated this knowledge by eliminating dextrose from routine intraoperative intravenous solutions. Subsequently, many human studies were performed looking for an association between hyperglycemia and outcome from stroke, cardiac arrest, and traumatic brain injury. Almost all studies found a strong correlation between hyperglycemia and worsened outcome. To date, however, the precise mechanism to explain this has been elusive, although the preponderance of data points to enhanced intracellular acidosis secondary to anaerobic glucose metabolism in the absence of oxygen. Later work in rats showed that controlling glucose with insulin could abate the adverse effects of hyperglycemia. Independent from concerns related to central nervous system injury, it has been reported that strict glucose control provides better outcome in a general intensive care unit (ICU) patient population. Although these results have been difficult to replicate, it seems logical to extend rigid glucose control to neurosurgical and neurocritical care patients who would seem at high risk for exacerbation of central nervous system injury.

The articles by Theile et al. and Bilotta et al. provide important lessons regarding glucose management in neurocritical care patients. Thiele et al. examined medical records collected between 1995 and 2007 from 834 patients with aneurysmal subarachnoid hemorrhage. Beginning in 2002, strict blood glucose control was practiced from admission to discharge, with the goal being maintenance in a range of 90–120 mg/dl. Outcomes were compared between patients treated before glucose control versus those treated after glucose control had been instituted. Glucose control was effective in decreasing the incidence of hyperglycemia. However, there was no effect on hospital mortality. This was, at least in part, attributed to an increased incidence of hypoglycemia in the glucose control group (table 1). Hypoglycemia events were associated with greater chance of death.

Bilotta et al. performed a prospective randomized analysis of strict glucose control (79–110 mg/dl) versus conven-

<table>
<thead>
<tr>
<th>Therapy: intensive vs. conventional insulin therapy</th>
<th>Odds Ratio (95% Confidence Interval)</th>
<th>P Value</th>
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<tbody>
<tr>
<td>Hypoglycemia (blood glucose values at the time of enrolment as a continuous variable)</td>
<td>0.996 (0.988–1.004)</td>
<td>0.3609</td>
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SAPS II = simplified acute physiology score II.
tional care in 483 patients during their ICU stay after brain surgery. The incidence of substantive hypoglycemia episodes was nearly tripled in the strict control group. Glucose control decreased ICU duration of stay and the incidence of infections, but there was no effect on 6-month Glasgow Outcome Scale scores or mortality. Each study has limitations, but cumulatively, these two studies make a major advance in our appreciation of the role of glucose management in neurocritical care patients. Although both studies found that strict glucose control protocols decreased average glucose concentrations, the magnitude of reduction was modest. At the same time, hypoglycemia was more frequent, and this plausibly stressed the injured brain. We now know that a systematic intervention designed to strictly control blood glucose during ICU stays can present hazard that may outweigh benefit. This should be considered when treating these patients. A different result may be found if the target range is allowed to be higher. In most laboratory studies, the threshold for hyperglycemia-augmented ischemic/traumatic brain injury seems to be approximately 180 mg/dl.


Application of manual in-line stabilization (MILS) is recommended to minimize pathologic cervical spine injury during direct laryngoscopy or other intubation procedures in patients with known or suspected cervical spine instability. However, MILS also worsens the laryngeal view and prolongs time required for tracheal intubation, potentially resulting in hypoxemia during the intubation procedure. There has therefore been a recent reconsideration of the clinical practice of MILS. This research group previously reported significant subluxation at the site of unstable cervical spine during direct laryngoscopy with MILS in the cadaveric injury model. Santoni et al. extended their previous work and added new convincing evidence suggesting disadvantages of MILS application during direct laryngoscopy. Using a sophisticated new technology for measuring distribution of laryngoscopic forces along the laryngeal blade, they clearly demonstrated that direct laryngoscopy with MILS doubled the forces compared with that without MILS, and degradation of glottic visualization and intubation failure occurred despite the increased laryngoscopic forces. The authors concluded that secondary increase of laryngeal forces with MILS application in the presence of cervical instability and impaired glottic visualization has the potential to increase pathologic craniocervical motion. The work from this team and others questions the benefit of MILS during direct laryngoscopy.


This study, in the current issue, is a post hoc analysis of a large database obtained in 44 French ICUs, which includes 1,381 mechanically ventilated patients. The authors show that patients assessed for pain on day 2 were more likely to receive sedation level assessment, nonopioid drugs, and dedicated analgesia during painful procedures and to receive fewer hypnotics. Moreover, patients with pain assessment had a shorter duration of mechanical ventilation (8 vs. 11 days; P < 0.01). Using a propensity score adjustment, these patients were weaned from the ventilator and discharged from the ICU earlier than those without pain assessment. This study is observational and thus causality cannot be definitely demonstrated and the interaction between analgesia and sedation is complex. However, this study should be considered as a cornerstone study on pain and its consequences in the ICU for the following reasons. First, this research concerns our three main domains of interest: anesthesia, critical care, and pain. Second, few studies addressed pain control in the ICU, and fewer implicated pain assessment as a factor in the outcome of critically ill patients. Third, there is an increasing interest in pain, comfort, and behavior of critically ill patients because they impact long-term outcome. This study illuminates the methodologic difficulties associated with this new research topic. It is remarkable that only 42% of critically ill patients were assessed for pain on day 2 in the DOLOREA study. What about your ICU?


Although morphine is the benchmark analgesic drug, use of this drug causes adverse effects. Some of these adverse effects include respiratory depression, nausea, analgesic tolerance, physical dependence, psychological dependence, and hyperalgesia. Most of these beneficial and adverse effects have been attributed to the parent drug, morphine, but it is well-known that morphine metabolites such as morphine-6-glucuronide and morphine-3-glucuronide are biologically active in patients.

Recently, the morphine metabolite morphine-6β-glucuronide has been shown not only to have analgesic properties but also to increase pain sensitivity. In this study, van Dorp et al. completed a translational study using mice and human subjects. The investigators and tested the effect of morphine-6-glucuronide for its analgesic and antianalgesic properties. Administration of morphine-6-glucuronide produced analgesia in normal mice but produced hyperalgesia in opioid receptor
hour. Values are mean 0.043 mg/kg (algesic response. Naloxone was given as an intravenous bolus of ground infusion, M6G causes an immediate and persistent hyper-
background exposure to naloxone. During a naloxone back-
experimental heat pain responses in human volunteers during
were blocked (fig. 3). Because morphine-6-glucuronide increased pain sensitivity even after opioid receptors
in patients with renal disease, these effects of morphine-6-glucuronide may contribute to the drug’s adverse effects. Therefore, the metabolite morphine-6-glucuronide may not only contribute to analgesia but also may counteract the analgesia by producing hyper-
algesia independent of opioid receptors.

Cohen SP, Bogduk N, Dragovich A, Buckenmaier CC, Griffith S, Kurihara C, Raymond J, Richter PJ, Williams N, Yaksh TL: Randomized, double-blind, placebo-con-
trolled, dose–response, and preclinical safety study of

Fig. 3. Influence of 0.4 mg/kg morphine-6β-glucuronide (M6G) on experimental heat pain responses in human volunteers during background exposure to naloxone. During a naloxone back-
knockout mice. Hyperalgesia was also produced when

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