Sepsis Is Associated with a Preferential Diaphragmatic Atrophy

A Critically Ill Patient Study Using Tridimensional Computed Tomography

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ABSTRACT

Background: Diaphragm and psoas are affected during sepsis in animal models. Whether diaphragm or limb muscle is preferentially affected during sepsis in the critically ill remains unclear.

Methods: Retrospective secondary analysis study including 40 patients, comparing control (n = 17) and critically ill patients, with (n = 14) or without sepsis (n = 9). Diaphragm volume, psoas volume, and cross-sectional area of the skeletal muscles at the third lumbar vertebra were measured during intensive care unit (ICU) stay using tridimensional computed tomography scan volumetry. Diaphragm strength was evaluated using magnetic phrenic nerve stimulation. The primary endpoint was the comparison between diaphragm and peripheral muscle volume kinetics during the ICU stay among critically ill patients, with or without sepsis.

Results: Upon ICU admission, neither diaphragm nor psoas muscle volumes were significantly different between critically ill and control patients (163 ± 53 cm³ vs. 197 ± 82 cm³ for the diaphragm, P = 0.36, and 272 ± 116 cm³ vs. to 329 ± 166 cm³ for the psoas, P = 0.31). Twenty-five (15 to 36) days after admission, diaphragm volume decreased by 11 ± 13% in nonseptic and by 27 ± 12% in septic patients, P = 0.01. Psoas volume decreased by 11 ± 10% in nonseptic and by 19 ± 13% in septic patients, P = 0.09. Upon ICU admission, diaphragm strength was correlated with diaphragm volume and was lower in septic (6.2 cm H₂O [5.6 to 9.3]) than that in nonseptic patients (13.2 cm H₂O [12.3 to 15.6]), P = 0.01.

Conclusions: During the ICU stay, both diaphragm and psoas volumes decreased. In septic patients, the authors report for the first time in humans preferential diaphragm atrophy compared with peripheral muscles. (Anesthesiology 2014; 120:1182-91)

The diaphragm is the main respiratory muscle, its dysfunction is one of the main causes of difficulties to wean from the ventilator in the intensive care unit (ICU) and sepsis affects its contractility in the critically ill.1-5 Along with others, we have recently confirmed in humans that mechanical ventilation (MV) per se is associated with diaphragm dysfunction, a condition named ventilator-induced diaphragmatic dysfunction.6,8 Although ventilator-induced diaphragmatic dysfunction has recently emerged as a potentially important clinical condition, sepsis has been reported to be associated with diaphragm dysfunction in relation with both myopathy and neuropathy9 and is the consequence of both functional (specific force generation) and morphological (atrophy) damages.10 However, whether limb muscles or diaphragm is similarly or differentially affected during sepsis remains controversial12,11-13 and determining the main victim may be helpful for clinicians confronted with patients recovering from severe sepsis. Indeed, the Extended Prevalence of Infection in Intensive Care study II reported an incidence of 46 to 60% of ICU beds occupied by a “sepsis case” around the world,14 and although as many as 33% of the patients eventually died during their hospital stay, more and more...
patients do survive after sepsis. However, these survivors increasingly present profound skeletal muscle weakness and there is a need to better identify and treat sepsis-induced myopathy in the critically ill patients.\textsuperscript{1} Our team developed a three-dimensional volumetry tool using computed tomography (CT)\textsuperscript{15–18} which may be of interest to compare diaphragm and peripheral muscle volume kinetics in the critically ill.

The aims of our study were therefore to compare diaphragm and psoas volumes between septic and nonseptic critically ill patients during the ICU stay and to describe the relation between diaphragm volume and diaphragm contractility in critically ill patients. We hypothesized that sepsis is associated with a preferential diaphragmatic atrophy, which is negatively correlated with diaphragm contractility.

**Materials and Methods**

**Study Design**

This study was conducted from July 2008 to August 2009 in a 16-bed medical–surgical ICU (Saint Eloi Teaching Hospital ICU, Montpellier, France) and is a retrospective secondary analysis of a trial performed with some of the patients (critically ill patients).\textsuperscript{2} Given that this post hoc analysis did not modify current diagnostic or therapeutic strategies, the need for written consent was waived according to the French Law (Law 88–1138 relative to Biomedical Research of December 20, 1988, modified on August 9, 2004). The study design is represented in figure 1.

**Study Population**

A flow chart of the study is represented in figure 2. Critically ill patients were included in the post hoc analysis if they were

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**Fig. 1.** Design of the study. Diaphragm force evaluation and the first computed tomography (CT) volume measurement were performed upon intensive care unit (ICU) admission. Second CT volume measurement was done during the ICU stay when a CT was indicated for diagnostic purposes.

**Fig. 2.** Flow chart of the study. CT = computed tomography.
admitted to the ICU and had had (1) an abdominal CT scan before the ICU admission, (2) a second abdominal CT scan during the ICU stay, and (3) at least one measure of diaphragmatic contractility by measuring the change in endotracheal tube pressure induced by application of bilateral magnetic twitch stimulation of the phrenic nerves during airway occlusion (TwPtr) while being intubated. Patients were excluded if the CT scan did not allow measurement of the diaphragm and the psoas muscle volumes (cut diaphragm and/or psoas and artifacts) or in the case of a previously identified chronic neuromuscular disease associated with muscle atrophy. Patients in the ICU group were separated into septic and nonseptic groups according to Bone’s criteria. Seventeen consecutive outpatients, explored with a virtual colonoscopy at our institution and who had a normal abdominal CT scan, served as controls (control group).

**Measurements**

We collected data for sex, age, height, weight, body mass index, Simplified Acute Physiology Score II, Sequential Organ Failure Assessment score, presence of a sepsis, length of ICU stay, and ICU mortality for all patients in the ICU (table 1).

**Table 1.** Characteristics of the 40 Studied Patients

<table>
<thead>
<tr>
<th></th>
<th>Controls (n = 17)</th>
<th>ICU Nonseptic (n = 9)</th>
<th>ICU Septic (n = 14)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (yr)</td>
<td>59±24</td>
<td>55±16</td>
<td>67±14</td>
<td>0.07</td>
</tr>
<tr>
<td>Male sex</td>
<td>9 (53)</td>
<td>6 (66)</td>
<td>8 (57)</td>
<td>0.79</td>
</tr>
<tr>
<td>Weight (kg)</td>
<td>80±13</td>
<td>79±21</td>
<td>73±23</td>
<td>0.32</td>
</tr>
<tr>
<td>Height (cm)</td>
<td>166±8</td>
<td>170±15</td>
<td>168±7</td>
<td>0.66</td>
</tr>
<tr>
<td>Body mass index (kg/m²)</td>
<td>28.8 ± 4.4</td>
<td>27.0 ± 4.8</td>
<td>25.6 ± 7.0</td>
<td>0.36</td>
</tr>
<tr>
<td>Past medical history</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COPD</td>
<td>1 (6)</td>
<td>1 (11)</td>
<td>1 (7)</td>
<td>0.88</td>
</tr>
<tr>
<td>Cancer</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>2 (14)</td>
<td>0.15</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>2 (12)</td>
<td>2 (22)</td>
<td>4 (28)</td>
<td>0.50</td>
</tr>
<tr>
<td>SAPS II upon ICU admission</td>
<td>NA</td>
<td>42±14</td>
<td>53±22</td>
<td>0.18</td>
</tr>
<tr>
<td>SOFA score upon ICU admission</td>
<td>NA</td>
<td>6±3</td>
<td>8±4</td>
<td>0.20</td>
</tr>
<tr>
<td>ICU length of stay (days)</td>
<td>NA</td>
<td>24±17</td>
<td>34±26</td>
<td>0.36</td>
</tr>
<tr>
<td>Sedation</td>
<td>NA</td>
<td>9 (100)</td>
<td>14 (100)</td>
<td>&gt;0.99</td>
</tr>
<tr>
<td>Neuromuscular-blocking agent (days)</td>
<td>NA</td>
<td>0 (0–0)</td>
<td>0 (0–1)</td>
<td>0.10</td>
</tr>
<tr>
<td>Duration of sedation (days)</td>
<td>NA</td>
<td>6 (3–19)</td>
<td>7 (3–11)</td>
<td>0.81</td>
</tr>
<tr>
<td>Duration of controlled mechanical ventilation (days)</td>
<td>NA</td>
<td>4 (3–7)</td>
<td>6 (5–8)</td>
<td>0.49</td>
</tr>
<tr>
<td>Duration of pressure support ventilation (days)</td>
<td>NA</td>
<td>11 (6–21)</td>
<td>12 (5–21)</td>
<td>0.78</td>
</tr>
<tr>
<td>Noninvasive ventilation (days)</td>
<td>NA</td>
<td>0 (0–3)</td>
<td>1 (1–4)</td>
<td>0.35</td>
</tr>
<tr>
<td>Fluid balance day 0 (ml)</td>
<td>NA</td>
<td>600 (−1,100 to 1,000)</td>
<td>1,700 (1,400–2,500)</td>
<td>0.02</td>
</tr>
<tr>
<td>Fluid balance day 1 (ml)</td>
<td>NA</td>
<td>1,100 (0–2,500)</td>
<td>800 (400–1,700)</td>
<td>0.99</td>
</tr>
<tr>
<td>Fluid balance day 2 (ml)</td>
<td>NA</td>
<td>1,100 (500–1,600)</td>
<td>−200 (−2,000 to 1,800)</td>
<td>0.27</td>
</tr>
<tr>
<td>Fluid balance day 3 (ml)</td>
<td>NA</td>
<td>600 (400–700)</td>
<td>200 (−1,200 to 1,300)</td>
<td>0.38</td>
</tr>
<tr>
<td>Fluid balance day 4 to 7 (ml)</td>
<td>NA</td>
<td>1,100 (−900 to 3,000)</td>
<td>0 (−1,200 to 1,200)</td>
<td>0.64</td>
</tr>
<tr>
<td>Parenteral nutrition (days)</td>
<td>NA</td>
<td>6 (1–9)</td>
<td>14 (12–25)</td>
<td>0.06</td>
</tr>
<tr>
<td>Enteral nutrition (days)</td>
<td>NA</td>
<td>9 (4–22)</td>
<td>13 (7–17)</td>
<td>0.54</td>
</tr>
<tr>
<td>Aminoglycosides (days)</td>
<td>NA</td>
<td>0 (0–2)</td>
<td>0 (0–2)</td>
<td>0.93</td>
</tr>
<tr>
<td>Hydrocortisone (total dose during the stay, mg)</td>
<td>NA</td>
<td>0 (0–1,400)</td>
<td>1,450 (1,000–1,700)</td>
<td>0.03</td>
</tr>
<tr>
<td>Day 28 survival</td>
<td>NA</td>
<td>8 (89)</td>
<td>11 (79)</td>
<td>0.52</td>
</tr>
</tbody>
</table>

Data are mean and SD or mean and quartiles or number and percentages. There was no statistically significant difference between ICU nonseptic and septic groups for the reported data. P value is between ICU nonseptic and ICU septic patients.

COPD = chronic obstructive pulmonary disease; ICU = intensive care unit; NA = not applicable; SAPS II = Simplified Acute Physiology Score; SOFA = Sequential Organ Failure Assessment score.
areas of all those muscles were summed and expressed as normalized to body surface. We assessed whether diaphragm and psoas volumes were correlated with weight, height, and body mass index.

Diaphragmatic contractile function was evaluated as previously described. In brief, we measured the change in endotracheal tube pressure provoked by application of bilateral magnetic twitch stimulation of the phrenic nerves during airway occlusion. TwPtr was obtained upon ICU admission but not afterwards as detailed in a previous study from our group. In the control group, no diaphragmatic contractile measure was performed.

Fig. 3. Psoas and diaphragm volume measurements with three-dimensional computed tomography reconstruction and dedicated software for volumetry measurement (Advantage Window 4.5 with Volume Viewer; General Electric, Milwaukee, WI). After circling, the diaphragm and the psoas shapes on millimetric slide (A), the software automatically isolated the diaphragm from the abdomen and the chest wall (B, C), and calculated the diaphragm volume (average volume $163 \pm 53$ cm$^3$). Psoas volumes were measured using the same technique (average volume $272 \pm 116$ cm$^3$) (D). Cross-sectional area of the paraspinal and abdominal wall muscles was measured at the level of the third lumbar vertebra (average cross sectional area $17.1 \pm 5.4$ cm$^2$/m$^2$ (E).
Study Endpoints
The primary endpoint was to compare diaphragm and psoas volume changes between septic and nonseptic critically ill patients. The secondary endpoint was to describe the relation between diaphragm volume and diaphragm contractility.

Statistical Analysis
The results are expressed as mean ± SD, median (25th to 75th percentiles), and number and percentage. Demographic characteristics, muscle volumes, and muscle surfaces were compared between controls, nonseptic, and septic patient groups using the Kruskal–Wallis, repeated-measure ANOVA, or chi-square tests according to the distribution of the variables. To compare volume kinetic in the critically ill according to the presence or the absence of sepsis, the Wilcoxon rank sum test for paired data was used. The Pearson correlation coefficient was used to assess the correlation between the muscle volume and weight, height, body mass index, and contractility. After preliminary measures conducted for the current study, we assumed a mean diaphragm volume of approximately 210 cm³ with an SD of 60 cm³ in the control patients. We then hypothesized a 30% decrease in diaphragmatic volume in critically ill during the ICU stay. Because we did not expect the possibility of muscle hypertrophy during the ICU stay, we calculated that 12 patients per group would be necessary to test our hypothesis with 80% statistical power and a one-sided α value of 0.05. Statistical analysis was performed by the Medical Statistical Department of the Montpellier University Hospital (N.M.), with R software (v2.15.2; Vienna, Austria). A P value of less than 0.05 was considered statistically significant.

Results
A total of 40 patients were included. Seventeen constituted the control group and 23 in the ICU group; of the ICU group, 14 of them were septic and 9 were not septic (fig. 2). Table 1 shows their main characteristics. No differences were observed among septic and nonseptic patients. Sepsis started 2 days (3 to 5) before ICU admission. Nine of the 14 septic patients presented with an intraabdominal infection, 4 presented with a pneumonia, and 1 presented with an endocarditis. Among the nine patients without sepsis, three were admitted for multiple trauma, three for scheduled esophageal surgery, one for acute on chronic respiratory failure, and two for acute liver failure.

Diaphragm and psoas volumes were both correlated with weight, height, and body mass index (fig. 4).

In the ICU group, the first diaphragm volume measurement, performed the day of admission (−3 to 0) (with extremes ranged from 33 days before admission to...
1-day postadmission), was 163 ± 53 cm³ compared with 197 ± 82 cm³ in the control group (P = 0.36). The first psoas volume measurement was 272 ± 116 cm³ in the ICU group compared with 329 ± 166 cm³ in the control group (P = 0.31).

The second volume measurement was performed 25 (15 to 36) days after the first measurement. In the critically ill, diaphragm volume decreased from 163 ± 53 cm³ to 130 ± 52 cm³ (P < 0.01) during the ICU stay. Psoas volume decreased from 272 ± 116 cm³ to 233 ± 108 cm³ (P < 0.01) during the ICU stay. No correlation was found between diaphragm or psoas volume loss and time between the two CTs. Cross-sectional areas of skeletal muscles at the level of the third lumbar vertebra did not significantly decrease during the ICU stay (first measurement: 17.1 ± 5.4 cm²/m² and second measurement: 16.1 ± 5.2 cm²/m²). When the volume drop between the two measures was considered, septic patients experienced a larger decrease of diaphragmatic volume compared with that by the nonseptic patients (fig. 5A). On the contrary, comparing changes in psoas volume and muscle surface on the level of the third lumbar vertebra between septic and nonseptic patients revealed no differences (fig. 5, B and C).

Contractile function of the diaphragm upon ICU admission was evaluated after magnetic stimulation of the phrenic nerves. Tracheal pressure was 9.8 cm H₂O (6.0 to 13.1). Upon ICU admission, tracheal pressure was lower in the septic patients (6.2 cm H₂O [5.6 to 9.3]) compared with the nonseptic patients (13.2 cm H₂O [12.3 to 15.6]), P = 0.01. Diaphragm volume was correlated with tracheal pressure obtained upon ICU admission (r = 0.43 [0.02 to 0.72], P = 0.04) (fig. 6). One representative patient is presented on figure 7.

**Discussion**

This study, through combined functional and morphological data, shows for the first time in humans that sepsis is associated with preferential loss of diaphragm volume compared with the psoas. This loss of volume was associated with a lower diaphragm contractile force, evaluated by magnetic stimulation of the phrenic nerves.

**Fig. 5.** (A) Diaphragm volume kinetic between the two volume measurements in nonseptic patients and septic patients. Compared with the first measurement, volume drop was larger in septic (162 ± 55 cm³ to 120 ± 52 cm³) than that in nonseptic patients (164 ± 53 cm³ to 145 ± 51 cm³) (P = 0.01). (B) Psoas volume kinetic between the two volumes measurements in nonseptic patients and septic patients. Volume drop did not differ between the two groups. (C) Skeletal total muscle surface measured at the level of the third lumbar vertebra in nonseptic patients and septic patients. Surface drop did not differ between the two groups.

**Fig. 6.** Correlation between tracheal pressure measured upon intensive care unit admission and the first diaphragm volume measured upon admission (0 day [-3 to 0] before admission) in septic and nonseptic patients. There was a correlation between tracheal pressure (Ptrach) and diaphragm volume (r = 0.43 [0.02–0.72], P = 0.04). Regardless of the diaphragm volume, all but two septic patients had a Ptrach below 11 cm H₂O, which is the threshold of diaphragm dysfunction.²
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Our study has some limitations. It is a single-center study with limited patients. It highlights the atrophy that occurred during the ICU stay and provides additional data about diaphragmatic susceptibility to atrophy in the case of sepsis, but lacks mechanistic explanations, as well as data about psoas contractile force because of the study's design. However, obtaining diaphragm biopsies in humans who do not need surgery is not acceptable regarding the risk of such biopsies. Diaphragm volume was measured without data about inspiration–expiration cycling. Although knowing lung volume is of interest when diaphragm volume is evaluated, diaphragm volume measurement was performed using the same technique for all critically ill patients, thereby diluting the impact of lung volume on diaphragm volume in the current study. Finally, we provided only two measurements of muscle volume, but repeating high-resolution CT scans would have been outside the standard of care.

In the current study, we used the same technique as we did in other situations with the aid of an experienced radiologist.

Fig. 7. Illustrative case. Mean and SD volume variation is labeled for the critically ill groups. (A) Mean diaphragm volume drop comparison between septic and nonseptic patients. Volume drop was significantly greater in the septic patients compared with that in the nonseptic patients, *P* = 0.01. (B) Mean psoas volume drop comparison between septic and nonseptic patients. Volume drop was not affected by the presence of sepsis, *P* = 0.09.
energy supply, increased catabolism, proteolysis, and protein the consequence of several mechanisms such as inadequate et al muscle atrophy and neuromuscular impairment. Prolonged stay in the ICU has been associated with skeletal and diaphragm volumes decreased during the ICU stay.

Critically ill patients (75%) may have explained the absence of differences between diaphragm and psoas volumes between controls and critically ill. In the current study, we report the absence of diaphragm and psoas volume differences between the 17 controls and the 23 critically ill patients upon ICU admission. The absence of previous diseases that are known to be associated with diaphragmatic atrophy (e.g., chronic obstructive pulmonary disease or cancer) in 17 among 23 critically ill patients (75%) may have explained the absence of diaphragm and psoas volumes between controls and critically ill.

In the current study, we combined functional and morphological analyses and reported that as soon as the patient is admitted to the ICU, diaphragm contractile force is decreased in septic compared with nonseptic patients. We also determined a statistically significant correlation coefficient between diaphragm volume and force.

In conclusion, in septic patients, the current study reports a preferential loss of diaphragm volume compared with psoas. Upon ICU admission, diaphragm volume was correlated with diaphragm force, evaluated using magnetic stimulation of the phrenic nerves. Muscle volume measurement using dedicated tridimensional CT scan software may be considered for global evaluation of diaphragm atrophy in the critically ill. The association between muscle volume and function remains to be explored.

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Competing Interests
Dr. Jung reports personal fees from Merck (Whitehouse Station, New Jersey) and Astellas (Tokyo, Japan) without relations with the current study; Dr. Futier reports consulting fees from General Electric Medical System (Milwaukee, Wisconsin), and lecture fees from Fresenius Kabi (Bad Homburg, Germany) without relations with the current study; Dr. Jaber reports personal fees from Marquet (Getinge, Sweden), Draeger (Lübeck, Germany), Hamilton Medical (Bonaduz, Switzerland), Fisher Paykel (Auckland, New Zealand), and Abbott (Abbott Park, Illinois) without relations with the current study. All other authors have no competing interests.

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References


polynuropathy in septic patients with prolonged weaning from mechanical ventilation: Is the diaphragm also affected? A pilot study. Respir Care 2012; 57:1594–601

ANESTHESIOLOGY REFLECTIONS FROM THE WOOD LIBRARY-MUSEUM

“HANSGEN” Amber Bottle for the Wachter Chloroform Dropper

This blown-in-mold bottle was typical of the singly flat-sided flasks mass-produced for storing and dropping chloroform. That anesthetic’s potency ensured that a relatively small bottle could deliver an anesthetic of short to medium duration. Imitating the Esmarch Chloroform Kit, many practitioners carried dropper bottles inside concave wireframe masks. The amber coloring of the glass was believed to slow light degradation of chloroform. Topped here by the American-designed Wachter Chloroform Dropper (patent Figure 1, left), this “HANSGEN”-embossed bottle (right) shared the granular mold markings and air inclusions that frequently contributed to the shattering of these thin-walled bottles. (Copyright © the American Society of Anesthesiologists, Inc.)

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