Intranasal Application of Xenon Reduces Opioid Requirement and Postoperative Pain in Patients Undergoing Major Abdominal Surgery

A Randomized Controlled Trial

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ABSTRACT

Background: Both central sensitization after peripheral tissue injury and the development of opioid tolerance involve activation of N-methyl-D-aspartate (NMDA) receptors. At subanesthetic doses the NMDA receptor antagonist xenon suppresses pain-evoked sensitization of pain-processing areas in the central nervous system. Although numerous studies describe the effect of NMDA receptor antagonists on postoperative pain, clinical studies elucidating their intraoperative analgesic potency when applied in a low dosage are still largely missing.

Methods: To analyze the analgesic effect of low-dose xenon using new application methods, the authors tested nasally applied xenon as an add-on treatment for analgesia in 40 patients undergoing abdominal hysterectomy. Within a ran-
tion.1–3 NMDA receptor antagonists such as ketamine and dextromethorphan have been shown to be useful in the reduction of acute postoperative pain and analgesic consumption. Small doses of NMDA receptor antagonists led to a reduced postoperative requirement of opioids and suppressed the development of tolerance to opioids and opioid-induced hyperalgesia.4–6 Therefore, a concomitant application of small doses of NMDA receptor antagonists within a concept of multimodal analgesia is suggested.4,7

Xenon—An Ideal Anesthetic Agent
The noble gas xenon derives its name from the Greek “stranger” because of its rarity, representing no more than 8.75 × 10−6 % of the atmosphere.8 For more than 50 yr9 xenon has been used in clinical anesthetic practice10 and has proven to be a potent inhalation anesthetic with analgesic and organ-protective properties.11,12 The preponderance of evidence is that xenon acts via noncompetitive inhibition of NMDA receptors.12–14 However, it cannot be ruled out that other targets of xenon also mediate inhibitory effects of the noble gas.15–18 Xenon’s safety and efficacy profile currently appear to be unequaled, and only its relatively high costs and limited resources have precluded its widespread clinical use.11

Intranasal Drug Application
Intranasal drug administration is a noninvasive method that allows therapeutic agents that do not cross the blood–brain barrier to be delivered to the central nervous system (CNS). This method eliminates the need for systemic delivery, thereby reducing unwanted systemic side effects.19–22 Lipid-soluble agents are absorbed rapidly and efficiently across the nasal membrane into the bloodstream via the transcellular pathway with a plasma profile resembling that of an intravenous injection. Once these agents reach the bloodstream, they can diffuse freely through the blood–brain barrier and reach the CNS. This diffusion is qualified by the degree of lipid solubility and molecular size, with small lipophilic atoms such as xenon passing through the membrane more easily than larger and polar molecules.20 Therefore, intranasal delivery may offer a new economic strategy for targeting xenon to the brain and avoid excessive loss by exhalation.22

Rationale for the Study
Approximately 30–80% of patients complain about moderate to severe postoperative pain and inadequate postoperative pain relief may delay recovery, lead to a prolonged hospital stay, and increase medical costs.23–26 In a recently published study using functional neuroimaging, we found xenon to inhibit the CNS response in regions associated with pain processing such as the insular and primary somatosensory cortices.1 Moreover, increased pain tolerance induced by intranasally applied xenon has already been observed in a placebo-controlled experimental human study.22 To analyze the analgesic effect of low-dose xenon using a new application method within the clinical setting, we tested nasally applied xenon as an add-on treatment for analgesia in patients undergoing abdominal hysterectomy. We predicted that xenon relieves postoperative pain serving as the main effect variable. Furthermore, we predicted that intraoperative and postoperative requirements of opioids representing indirect indicators of treatment effects would decrease under xenon compared with placebo.

Materials and Methods

Subjects
The entire study was conducted from October 2008 to April 2009 at the Department of Gynecology and Obstetrics of the University Hospital of Ulm, Germany. We recruited 40 American Society of Anesthesiologists physical status I and II patients scheduled for elective abdominal hysterectomy (fig. 1). Recruitment by the involved gynecologist was always performed at least 1 day before surgery. The unpaid patients gave written informed consent before the study conforming with the Declaration of Helsinki and in accordance with the local ethics board (University of Ulm). None had a history of neurologic or psychiatric disorders or any sign of a nasopharyngeal disease. A history of adverse reactions to anesthetics, diabetes mellitus, any relevant renal, liver, or heart (including arterial hypertension) disease, regular alcohol consumption of more than 20 g per day,27 drug abuse, or taking sedatives or long-acting analgesic drugs were the exclusion criteria.28

Monitoring Drugs and Drug Delivery
Patients were monitored with a five-lead electrocardiogram, noninvasive blood pressure sampling, and pulse oximetry (patient monitoring system; Datex-Ohmeda, Helsinki, Finland) at a sample rate of 5 min. A Primus anesthesia work-station (Dräger, Lübeck, Germany) fitted with a desflurane (Baxter, Deerfield, IL) vaporizer unit was used to measure end-expiratory carbon dioxide and desflurane concentrations. A Bispectral Index (BIS) module (BIS® brain monitor, Aspect Medical Systems, Norwood, MA) integrated into the patient monitoring system was used to continually analyze the level of consciousness during anesthesia. Although the BIS has been shown to be suitable to survey the depth of hypnosis29 during xenon-induced anesthesia, the effect of low-dose xenon on BIS values is unknown. Therefore, data were recorded but not displayed during surgery to ensure blinding. Syringe pumps (Perfusor compact, B/Braun, Melsungen, Germany) were used for intraoperative administration of remifentanil (GlaxoSmithKline, London, United Kingdom) and postoperative patient-controlled opioid application (Graseby PCA Pump 3300, SIMS Graseby, Watford, United Kingdom). Morphine (Merck Pharma GmbH, Darmstadt, Germany) demand doses were 2 mg with a 4-min application period followed by a 6-min lockout pe-
Assessment of intensity of acute pain was performed using the 11-point numeric rating scale (0 –10; 0 = no pain and 10 = unbearable pain).24,30 The xenon application system contained a low-pressure metalized gas reservoir, xenon-proof tubes connected by multidirectional stopcocks and tube clamps (B/Braun), a pressure control unit (data recording; Greisinger GMH 3150, Regenstauf, Germany), two peristaltic pumps for flow adjustment (Bäder, Ulm, Germany), and a drain tube placed in the mouth of the patient leading to exhaust (fig. 2). Therefore, concentrations of xenon within the nasopharyngeal space could be kept constant over time and never decreased below 80% ([Xe]exhaust = 89.7 ± 4.6%; 2 volunteers, unblinded; assessed 10’, 20’, and 30’ after start of application). Air and xenon were delivered at a rate of 1.0 l/h. Xenon 4.0 was obtained from Air Liquide Santé International (Paris, France).

Study Design
This was a prospective, randomized, double-blind, parallel-group trial to evaluate the effects of nasally applied xenon on intraoperative and postoperative opioid requirement and postoperative evaluated pain scores. Because there were only two treatment arms (air, xenon) with an a priori fixed number of patients (20 per each arm), a simple randomization scheme was used with a vector of random numbers to generate an a priori list for randomized treatment assignments. According to this randomization list, patients received either xenon or air. The study supervisor, who did not participate in the assessment, prepared an unlabeled gas reservoir filled with either the colorless and odorless xenon or air as placebo. The anesthetists who provided the anesthesia and the intensive care unit (ICU) staff participating in the pain assessments were blinded for individual treatments. Patients were also blinded for group assignment and both blindings were maintained until the end of the study. The patients were asked to abstain from alcohol and excessive coffee consumption (defined as 5 cups or 400 mg caffeine31) for 24 h and from drinking and eating for 8 h before undergoing surgery. They were informed that the intranasal application device would deliver either xenon or placebo (air). The patients received a standardized oral and written instruction on the study design and postoperative usage of numeric rating scales and patient-controlled analgesia (PCA) devices on the evening before surgery. The same physician performed anesthesia and acquisition of intraoperative data. Postoperative assessment of pain was obtained by ICU staff using numeric rating scales. As a second and more indirect index for postoperative pain, the requirement of morphine was recorded by PCA pumps. Individual histories of require-
Premedication with 0.03 mg/kg midazolam and infusion of 6.25 ml/kg hydroxyethyl starch (6% 130/0.42, B/Braun) to ensure hemodynamic stability was performed 20 min before surgery (table 1). All patients intravenously received 1 g metamizole (Ratiopharm, Ulm, Germany), 4 mg ondansetrone (GlaxoSmithKline), and 0.2 mg glycopyrrolate (Riemser Arzneimittel AG, Greifswald, Germany) to avoid nasopharyngeal secretion and to ensure short diffusion distances. Anesthesia was induced by 1.5 mg/kg propofol (B/Braun), 1.5 \( \mu g/kg \) fentanyl (Janssen-Cilag, Neuss, Germany), and 0.35 mg/kg atracurium (GlaxoSmithKline) to facilitate tracheal intubation. After induction, desflurane was administered at 0.5 minimum alveolar concentration; using automatic minimum alveolar concentration level monitoring of the Primus anesthesia workstation with an oxygen flow of 300 ml/min. Application of xenon and infusion of remifentanil at a rate of 0.5 mg/h was started 10 min before onset of skin incision. Although the hypnotic state was kept constant at 0.5 minimum alveolar concentration and documented by real-time processing of electroencephalography signals (BIS), the infusion rate of remifentanil was adjusted to responses due to inadequate analgesia – either autonomic (e.g., indicated by an increase/decrease in systolic blood pressure or heart rate by more than 20% from baseline\(^{32}\); tearing, sweating) or somatic (e.g., movement).

At the time of removal of surgical dressing, the patients were connected to a PCA pump and a first bolus of 2 mg morphine was applied. After extubation was performed, all patients were taken to an ICU to ensure a safe and immediate opioid-based pain treatment. Metamizole (1 g) was applied intravenously every 6 h, and the patients had the option to obtain up to 12 mg/h morphine by the PCA pump. In addition, patients could receive morphine from ICU staff to intervals of 3 mg/10 min until they gain a numeric rating scale score of 4 in terms of an escape medication. Upon the patients’ arrival to ICU, sedation level was assessed with the Observer’s Assessment of Alertness/Sedation scale: 5 = responds readily to name spoken in normal tone; 4 = lethargic response to name spoken in normal tone; 3 = responds only after name is called loudly or repeatedly; 2 = responds only after mild prodding or shaking; and 1 = does not respond to mild prodding or shaking.\(^{33}\)

**Blood Gas Analysis**

The local ethics committee (University of Ulm) gave permission to this invasive investigation within two healthy volun-

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**Table 1. Study Design**

<table>
<thead>
<tr>
<th></th>
<th>Preparation 20 min</th>
<th>Surgery 125 min (Mean)</th>
<th>ICU 24 h</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supporting drugs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HES 6% 6.25 ml/kg</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Ondansetrone 4 mg</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Glycopyrrolate 0.2 mg</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Midazolam 0.03 mg/kg</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Atracurium 0.35 mg/kg</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Analgesic drugs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metamizole 1 g</td>
<td>—</td>
<td>—</td>
<td>— Metamizole 1 g</td>
</tr>
<tr>
<td>Fentanyl 1.5 ( \mu g/kg )</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Hypnotic Drugs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Propofol 1.5 mg/kg</td>
<td>— Desflurane 0.5 MAC, constant</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Verum/Placebo</td>
<td>—</td>
<td>— Xenon or Placebo</td>
<td>—</td>
</tr>
<tr>
<td>Opioid consumption</td>
<td>—</td>
<td>— Remifentanil</td>
<td>—</td>
</tr>
<tr>
<td>Pain assessment</td>
<td>—</td>
<td>— Adjusted to response</td>
<td>— Patient controlled</td>
</tr>
</tbody>
</table>

Assessment of treatment effects was performed measuring intraoperative requirement of remifentanil (while the hypnotic state was kept constant) and postoperative patient-controlled morphine consumption within a randomized double-blind placebo-controlled study design. In addition, postoperative treatment effects were assessed using an 11-point numeric rating scale (NRS). HES = Hydroxyethyl starch; ICU = intensive care unit; MAC = minimum alveolar concentration.
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Figure 3. Blood gas analysis. Concentrations of xenon measured in the blood \([\text{[Xe]}_{\text{BLOOD}}]\) of the internal jugular vein of two volunteers. Intranasal application of xenon for 30 min at a rate of 1.0 l/h followed by 20 min of washout using oxygen at a rate of 8 l/min. A steady state was reached within approximately 10 min providing evidence for a direct pathway from nose to brain.

Table 2. Patient Characteristics

<table>
<thead>
<tr>
<th>Variable</th>
<th>Placebo</th>
<th>SD</th>
<th>Xenon</th>
<th>SD</th>
<th>(t) (38)</th>
<th>(P) Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Size, cm</td>
<td>166.65</td>
<td>6.46</td>
<td>164.70</td>
<td>6.94</td>
<td>-0.920</td>
<td>0.363</td>
</tr>
<tr>
<td>Weight, kg</td>
<td>69.60</td>
<td>8.52</td>
<td>65.65</td>
<td>11.33</td>
<td>-1.246</td>
<td>0.220</td>
</tr>
<tr>
<td>BMI, kg/m²</td>
<td>25.18</td>
<td>3.88</td>
<td>24.29</td>
<td>4.43</td>
<td>-0.672</td>
<td>0.506</td>
</tr>
<tr>
<td>Age, yr</td>
<td>48.30</td>
<td>6.59</td>
<td>45.45</td>
<td>7.26</td>
<td>-1.300</td>
<td>0.201</td>
</tr>
<tr>
<td>ASA Category</td>
<td>1.75</td>
<td>0.44</td>
<td>1.55</td>
<td>0.51</td>
<td>-1.322</td>
<td>0.194</td>
</tr>
<tr>
<td>HR, beats/min</td>
<td>71.50</td>
<td>10.95</td>
<td>73.80</td>
<td>13.85</td>
<td>-0.628</td>
<td>0.534</td>
</tr>
<tr>
<td>MAP, mmHg</td>
<td>93.95</td>
<td>12.31</td>
<td>93.90</td>
<td>13.45</td>
<td>-0.012</td>
<td>0.990</td>
</tr>
</tbody>
</table>

There are no statistically significant differences between groups on either variable listed.

ASA = American Society of Anesthesiologists physical status category; BMI = body mass index; HR = heart rate; MAP = mean arterial pressure.
characteristics for both groups. All patients were hemodyn-
amically stable throughout the anesthetic period, and none
of the patients had an intraoperative blood loss greater than
100 ml. One patient in each group was excluded from post-
operative analysis – one accidentally received benzodiaz-
epines and the other had to be revised due to secondary
bleeding 6 h after extubation.

**Anesthesia**

During anesthesia all relevant parameters were comparable
for both groups: duration of surgery, desflurane dosage (end-
tidal desflurane concentration, minimum alveolar concen-
tration), oxygenation, ventilation (end-tidal carbon dioxide
concentration), and flow settings (fractional inspired oxygen
tension, gas flow). There were no significant group differ-
ences of the measured BIS values, blood pressures (mean
arterial pressure) or heart rates (table 3). Upon patients’ ar-
rival to the ICU there were no statistical significant differ-
ces of the sedation level (Observer’s Assessment of Alert-
ness/Sedation scale). Vomiting occurred in two patients in
each group (table 4).

**Treatment Effects on Primary Outcome Variables**

All treatment effects on the primary outcome variables are
summarized in table 5. With the hypnotic state kept constant
at 0.5 minimum alveolar concentration, the infusion rate of
remifentanil was adjusted to patient responses and could
therefore be used as an indicator for intraoperative analgesic
requirement. A two-tailed Student $t$ test contrast revealed
that remifentanil requirement was significantly reduced in
the xenon-treated group compared with placebo with an av-
erage reduction of $2.02 \mu g/min$ (fig. 4). Furthermore, sub-

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**Table 3. Anesthesia—Comparison of Groups**

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Placebo</th>
<th></th>
<th>Xenon</th>
<th></th>
<th>t (38)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duration of surgery/min</td>
<td>130.50</td>
<td>69.15</td>
<td>118.00</td>
<td>56.06</td>
<td>0.582</td>
<td>0.564</td>
</tr>
<tr>
<td>Desflurane$_{et}$/vol %</td>
<td>3.37</td>
<td>0.17</td>
<td>3.43</td>
<td>0.14</td>
<td>1.121</td>
<td>0.269</td>
</tr>
<tr>
<td>MAC</td>
<td>0.50</td>
<td>0.004</td>
<td>0.50</td>
<td>0.01</td>
<td>0.904</td>
<td>0.372</td>
</tr>
<tr>
<td>BIS</td>
<td>47.71</td>
<td>8.17</td>
<td>49.17</td>
<td>6.36</td>
<td>0.631</td>
<td>0.532</td>
</tr>
<tr>
<td>HR/bpm</td>
<td>61.22</td>
<td>9.42</td>
<td>56.83</td>
<td>8.40</td>
<td>-1.556</td>
<td>0.128</td>
</tr>
<tr>
<td>MAP/mmHg</td>
<td>84.37</td>
<td>11.59</td>
<td>79.83</td>
<td>10.06</td>
<td>-1.324</td>
<td>0.193</td>
</tr>
<tr>
<td>enCO$_2$</td>
<td>36.51</td>
<td>1.12</td>
<td>35.80</td>
<td>1.51</td>
<td>-1.650</td>
<td>0.107</td>
</tr>
<tr>
<td>FIO$_2$</td>
<td>0.58</td>
<td>0.07</td>
<td>0.59</td>
<td>0.07</td>
<td>0.256</td>
<td>0.799</td>
</tr>
<tr>
<td>SpO$_2$/%</td>
<td>98.70</td>
<td>0.47</td>
<td>98.97</td>
<td>0.43</td>
<td>1.660</td>
<td>0.105</td>
</tr>
<tr>
<td>Gas flow (O$_2$)/l/min</td>
<td>0.30</td>
<td>0</td>
<td>0.30</td>
<td>0</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Data obtained throughout anesthesia at a sample rate of 5 min (n [placebo] = 506; n [xenon] = 486). There are no statistically significant differences between groups on intraoperative conditions and treatment effects.

BIS = Bispectral index; enCO$_2$ = end-tidal carbon dioxide concentration; HR = heart rate; MAC = minimum alveolar concentration; MAP = mean arterial pressure; SpO$_2$ = peripheral oxygen saturation.

**Table 4. Summary of Postoperative Events**

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Placebo (n = 19)</th>
<th></th>
<th>Xenon (n = 19)</th>
<th></th>
<th>t (36)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>OASS (ICU)</td>
<td>4.37 0.68</td>
<td></td>
<td>4.32 0.82</td>
<td></td>
<td>-0.215</td>
<td>0.831</td>
</tr>
<tr>
<td>TFA (min)</td>
<td>30.79 18.36</td>
<td></td>
<td>29.95 15.78</td>
<td></td>
<td>-0.152</td>
<td>0.880</td>
</tr>
<tr>
<td>URA</td>
<td>7.42 6.13</td>
<td></td>
<td>4.57 3.934</td>
<td></td>
<td>-1.701</td>
<td>0.098</td>
</tr>
<tr>
<td>Vomiting</td>
<td>2</td>
<td></td>
<td>2</td>
<td></td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Excluded (postoperative)</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Morphin use (mg/24 h)</td>
<td>1,146</td>
<td></td>
<td>904</td>
<td></td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>PCA + ICU staff per group</td>
<td>57</td>
<td></td>
<td>12</td>
<td></td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>NRS 7–10 (severe)</td>
<td>9</td>
<td></td>
<td>1</td>
<td></td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>NRS 4–6 (moderate)</td>
<td>46</td>
<td></td>
<td>25</td>
<td></td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>NRS 1–3 (mild)</td>
<td>30</td>
<td></td>
<td>50</td>
<td></td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>NRS 0 (none)</td>
<td>10</td>
<td></td>
<td>19</td>
<td></td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

ICU = intensive care unit; NRS = Numeric rating scale; number of ratings within 24 h postoperative, classification (none - severe) according to [30]; OASS = Observer’s Assessment of Alertness/Sedation scale, data obtained upon arrival to the ICU; PCA = patient-controlled analgesia; TFA = Time to first request for analgesia; URA = Number of unsuccessful requests for analgesia due to PCA pump lockout time.
jective pain intensity averaged over five time points (time of arrival in the ICU and 3, 6, 12, and 24 h after extubation) was significantly decreased in the xenon than in the placebo group. Reduction of average pain intensity was 1.34 points (fig. 4) with respect to an 11-point numeric rating scale ranging from no pain (0) to worst pain imaginable (10).

Although overall morphine requirement was numerically reduced by approximately 0.01 mg/min on average in patients who had received xenon during surgery, this difference against the placebo group was not statistically significant.

**Discussion**

In this study we measured opioid requirement for major abdominal surgery within a randomized double-blind placebo-controlled study design. We showed that intranasally applied xenon significantly reduces intraoperative requirement of opioids without relevant side effects (e.g., vomiting, increased sedation) and reduces postoperative pain. Postoperative opioid consumption was only numerically decreased.

**Intranasal Application of Xenon**

Xenon in many respects is an ideal anesthetic agent with anesthetic, analgesic, and neuroprotective properties. The main limiting factor for the widespread use of xenon has been its very high cost. However, costs can be reduced using alternative application methods such as intranasal application avoiding excessive loss by exhalation. Nasally administered drugs are able to reach the CNS by neural pathways (olfactory and trigeminal) or the bloodstream. However, the apolar and highly lipophilic nature of the chemically inert and structureless xenon is well known and lipid-soluble agents are absorbed predominantly across the nasal membrane into the bloodstream with a bioavailability of up to 100%. Once in the bloodstream, they can diffuse freely through the blood-brain barrier and reach the CNS. In this study, we demonstrated a fast wash-in kinetic of xenon completed within approximately 10 min suggesting an extraneural route. Note that the pharmacokinetic analysis primarily represents a confirmation in humans for the a priori-obtained analysis in the cerebral compartment of pigs under comparable conditions. There are no statistically significant differences between xenon concentrations in the venous blood comparing both species. Therefore, we assume that after approximately 15 min an intracranial equilibrium state was reached, and based on these results we developed the timeline of our study design.

**Table 5. Summary Statistics of Primary Outcome Variables**

<table>
<thead>
<tr>
<th></th>
<th>Placebo</th>
<th>Xenon</th>
<th>MD</th>
<th>CES</th>
<th>test statistic</th>
<th>P</th>
<th>P corr</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remifentanil</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Requirement</td>
<td>10.42</td>
<td>8.39</td>
<td>2.02</td>
<td>0.87</td>
<td>t (38) = 2.74</td>
<td>0.0092</td>
<td>0.028</td>
</tr>
<tr>
<td>(µg/min)</td>
<td>2.83</td>
<td>1.69</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>—</td>
<td>9.09</td>
<td>7.61</td>
<td>0.53</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>—</td>
<td>11.74</td>
<td>9.18</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Morphine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consumption</td>
<td>0.042</td>
<td>0.033</td>
<td>0.009</td>
<td>0.58</td>
<td>t (36) = 1.79</td>
<td>0.0813</td>
<td>0.244</td>
</tr>
<tr>
<td>(mg/min)</td>
<td>0.016</td>
<td>0.014</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>—</td>
<td>0.034</td>
<td>0.026</td>
<td>-0.001</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>—</td>
<td>0.050</td>
<td>0.040</td>
<td>0.019</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain scores</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(NRS; 0–10)</td>
<td>3.69</td>
<td>2.35</td>
<td>1.34</td>
<td>1.19</td>
<td>t (36) = 3.66</td>
<td>0.0008</td>
<td>0.002</td>
</tr>
<tr>
<td>—</td>
<td>1.00</td>
<td>1.24</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>—</td>
<td>3.21</td>
<td>1.75</td>
<td>0.60</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>—</td>
<td>4.18</td>
<td>2.95</td>
<td>2.09</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Effect sizes are Cohen effect sizes (CES); Mean difference (MD) between both groups (placebo vs. xenon); NRS = numeric rating scale; 
P corr = Bonferroni correction adjusted P values according to the three Student t tests. Observed P values are two-tailed.

**Fig. 4.** Treatment effects on primary outcome variables. Intranasally applied xenon significantly reduces intraoperative requirement of opioids and postoperative pain. Box plots showing (A) group averages of intraoperative remifentanil requirement (µg/min) and (B) subjective pain ratings (0–10 numeric rating scale; 0 = no pain and 10 = unbearable pain) as group averages over the postoperative time course (24 h). NRS = numeric rating scale; SE = standard error of the mean.
Assessment of Xenon’s Effect
Numerous studies describe the effect of NMDA receptor antagonists on postoperative pain, and there is an ongoing discussion in the literature about application of treatment before or at the end of surgery. However, clinical studies elucidating their intraoperative analgesic potency in contrast to placebo or applied in a low dosage are still largely missing.

Postoperative opioid consumption is commonly used as an index for postoperative pain and was insignificantly decreased by about 20% within the xenon group of our study. This lack of significance is probably due to the hedonic component inherent in morphine because its pleasant and inebriating characteristics are well known.

Because postoperative usage of morphine is not only due to pain, subjective ratings of postoperative pain intensity evaluated by the ICU staff must be taken into consideration as the main outcome variable. Results clearly indicate that patients’ subjective feeling of pain was significantly reduced in the group that received xenon during surgery. Furthermore, based on previous studies this reduction also appears to be clinically relevant.

Patients were able to obtain up to 30 mg/h of morphine via PCA (12 mg/h) and ICU staff (18 mg/h). Note that despite this excessive dosage the patients of the placebo group were not able to reduce their pain to the level of patients who had received xenon. Therefore, our data suggest that opioids are inappropriate to mimic or completely replace the analgesic effect of xenon.

During general anesthesia hypnotic and analgesic drug effects are interacting. The hypnotic effects of anesthetic agents can be estimated by its end-tidal partial pressure and can be controlled by real-time processing of electroencephalography signals (e.g., BIS). Because opioid consumption was the primary intraoperative outcome parameter in this study, all patients received a general balanced anesthesia with desflurane at 0.5 minimum alveolar concentration to minimize the influence of hypnotic drugs on pain processing.

We used remifentanil to prevent responses due to inadequate analgesia – indicated either autonomically (e.g., blood pressure, heart rate, tearing) or somatically (e.g., movement).

The pharmacokinetic profile of remifentanil is relatively unaltered by extremes of age and the presence of coexisting conditions such as obesity. Its blood concentration has been found to be proportional to the dose administered throughout the recommended dose range. Therefore, remifentanil is an ideal agent to achieve comparable results relatively independent of patient characteristics. Because both groups (placebo and xenon) were similar in terms of end-tidal desflurane concentrations and BIS values, a constant and comparable hypnotic state of the patients can be assumed. Therefore, the additional intraoperative requirement of remifentanil in the placebo group of approximately 25% can clearly be attributed to a relatively increased pain perception – or in other words to an analgesic effect of nasally applied xenon. These results are in accordance with clinical studies using high-dose xenon (F\text{Xe} = 70%) leading to a significantly reduced requirement of opioids or hypnotic anesthetics to suppress noxious stimulation.

The Effect of NMDA Receptors on Pain Perception
Although several other molecular targets have been discussed on which xenon may exert its effects under certain in vitro conditions, the NMDA receptor type is thought to be the prime molecular effect site for xenon’s analgesic properties in vivo. Central sensitization results mainly from the activation of glutamate receptors in the CNS triggered by nociceptive afferent input from the periphery. In a recently published study, we showed an enhanced responsiveness of pain processing areas to repeated painful stimulation using functional magnetic resonance imaging experiments. This enhancement was suppressed by the NMDA receptor antagonist xenon at subanesthetic doses providing evidence for an involvement of NMDA receptors in pain-evoked long-term potentiation related synaptic plasticity in the human brain.

Moreover, we described an increased pain tolerance induced by intranasally applied xenon within a multimodal and multistructured placebo-controlled experimental human study.

In the current study we showed that xenon significantly reduces postoperative pain in patients by more than 30% within the first 24 h after major abdominal surgery. This is in accordance with clinical studies using the NMDA receptor antagonists ketamine or dextromethorphan. Because fast removal of xenon by exhalation after terminating the delivery at the end of surgery is suggested by the kinetic study (see fig. 3), the postoperative effect of xenon is far beyond the duration of its presence in the biophase in concentrations that can provide direct pharmacologic effects. Decreased pain intensity beyond this point is regarded as the indirect effect resulting from prevention of pain sensitization processes.

Therefore, the postoperatively reduced pain intensity is well explained by suppressed pain-evoked long-term potentiation related processes of synaptic plasticity. Because sensitization processes occur within 30 min, they may also contribute to the decreased intraoperative analgesic requirement within in this study.

Furthermore, there are also relevant interactions between NMDA receptors and opioids. Although morphine, fentanyl, and other opioids produce antinociception through µ-receptor agonist activity and the activation of monoaminergic descending pathways at the spinal level, they also activate NMDA receptors, resulting in hyperalgesia and the development of tolerance to opioids. Remifentanil, the opioid we used in this study to determine intraoperative analgesic requirement, presents distinguishing characteristics compared with other opioids. It is a potent, short-acting opioid metabolized by plasma and tissue esterases. These interesting properties allow infusion of high doses during a short time period without compromising a predictable and rapid recovery. However, recent human studies have demonstrated difficult postoperative pain management and remifentanil was described to potentiate NMDA recep-
tor activity via μ-opioid receptors leading to hyperalgesia. Thus, if this was the type of tolerance or resistance involved in the intraoperative response to surgical stimulation in our patients, then the improved analgesia of the xenon group can be explained by an interaction of xenon with NMDA receptors that could have been activated by either or both of the perioperative nociceptive inputs and by the administration of opioids.

Conclusion

The concept of multimodal analgesia is the current trend in postoperative pain management. This implies that a single antagonist may not be sufficient to prevent postoperative pain if other pathways are not blocked. Low-dose xenon sufficiently reduces pain perception and analgesic use as demonstrated by functional magnetic resonance imaging measurements, experimental pain studies, and the results of this clinical study. Intranasally delivery offers a new economic strategy for targeting xenon to the brain and the promising results presented here call for future studies to determine the relevance of this application method as an add-on treatment for analgesia and neuroprotection under several clinical conditions.

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