The Electroencephalographic Pattern during Anesthesia with Éthrane:

Effects of Depth of Anesthesia, PaCO₂, and Nitrous Oxide

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The EEG patterns of increasing depths of Éthrane-O₂ anesthesia and the alterations in the patterns produced by changing PaCO₂ and by addition of 60 per cent nitrous oxide have been evaluated in 30 individuals. Increasing depth of anesthesia was characterized by the appearance of high-voltage spikes, with the subsequent development of spike waves and burst suppression. Maximum depth was marked by a predominance of spike waves and burst suppression. The anesthetic depth and PaCO₂, at which changes occurred have been defined. With elevation of PaCO₂ indices of cerebral irritability appeared to be reduced, while reduction of PaCO₂ increased their occurrence. The greatest CO₂ effect was seen at inspired Éthrane concentrations of 2.5 per cent or more. The addition of nitrous oxide did not alter the predominant EEG patterns. (Key words: Electroencephalogram; Nitrous oxide; Éthrane; Carbon dioxide.)

Clinical studies of Éthrane (1,1,2-trifluoro-2-chloroethyl difluoromethyl ether) have indicated that the agent has merit because of ease of administration, a high degree of patient acceptance, stability of cardiac rhythm, and the ability to produce excellent muscle relaxation. Preliminary data show that the compound undergoes limited biodegradation.

The rare occurrence of abnormal motor movements and occasional electroencephalographic (EEG) evidence of cerebral irritability during Éthrane anesthesia have caused concern. These findings have been most frequently associated with deep levels of anesthesia and with hypoxemia. This study was undertaken to identify in man under controlled conditions to EEG patterns characteristic of increasing depths of anesthesia with Éthrane and the alteration in the EEG produced by changing PaCO₂. The influence of nitrous oxide on the EEG was also evaluated. Our results indicated that Éthrane can be administered in clinically useful concentrations with or without hyperventilation with minimal EEG signs of cerebral irritability, and the addition of nitrous oxide did not appear to alter the EEG importantly.

Methods

Informed consent was obtained from all individuals. Patients agreed to the use of Éthrane during elective surgery, and anesthetic and PaCO₂ levels were selected according to standard anesthetic practices. Healthy subjects agreed to the use of Éthrane over a wider range of anesthetic doses and PaCO₂ levels and accepted the possibility of gross seizure activity. Data was gathered from two groups, 21 individuals (11 healthy subjects and 10 patients) not receiving added nitrous oxide (Group I), and nine patients to whom nitrous oxide was administered in addition to Éthrane (Group II).

Premedication for all individuals consisted of atropine, 0.5 mg iv or im, 15 to 90 minutes before anesthesia. Anesthesia was induced with Éthrane-O₂ or Éthrane-nitrous oxide-O₂. Tracheal intubation was accomplished within 10 minutes without succinylcholine in 15 individuals and with succinylcholine, 60-100 mg.
mg iv, in 15 individuals. Nitrous oxide was then discontinued. In Group II nitrous oxide was later added. Seventy per cent of the individuals received d-tubocurarine (mean dose 19 mg) during light anesthesia to prevent movement for experimental purposes and to provide adequate muscle relaxation.

Éthrane was administered with a Draeger vaporizer, Copper Kettle, or Éthrane vaporizer manufactured by Cyprene Ltd., in either a nonrebreathing or a circle system with a flow greater than 5 L/min. Constant minute ventilation was maintained by a mechanical ventilator at greater-than-normal minute ventilation to produce the lowest $P_{aCO_2}$ desired. Changes in $P_{aCO_2}$ were produced by addition of $CO_2$ to the anesthetist system.

Anesthetic concentrations were measured by a Biomedical Gas Chromatograph, model 400, using volumetrically prepared standards. Inspired gas and mixed expired gas were sampled and a stable anesthetic state was considered to exist when the mixed expired concentration was within 85% of the inspired concentration. Éthrane concentrations reported are the inspired values when this stable state existed. Arterial blood gases and pH were measured by Instrumentation Laboratory electrodes using procedures and correction factors described elsewhere. Steady-state $P_{aCO_2}$ was achieved by end-tidal monitoring, with a period of at least 15 minutes of stable $CO_2$ in the healthy subjects and a minimum equilibration period of 30 minutes following a $CO_2$ change in patients.

The EEG was recorded with a Grass Model
50 polygraph using uni- or bilateral frontoparietal leads in patients and with a Grass Model G electroencephalograph using six leads in healthy subjects.

**GROUP I**

Of the subjects in Group I, eight were maintained at a selected constant $\text{Paco}_2$ and were exposed to a variety of stable anesthetic states of Ethrane. Nine were maintained at a selected constant Ethrane concentration and $\text{Paco}_2$ was varied. The other four were studied both: a selected constant $\text{Paco}_2$ with variation in stable Ethrane concentrations followed by a selected stable Ethrane concentration and varied $\text{Paco}_2$.

**GROUP II**

Following Ethrane–O$_2$ anesthesia, EEG, anesthetic concentration and $\text{Paco}_2$ were determined. Nitrous oxide, 3 liters, and oxygen, 2 liters, were then added to the same Ethrane concentration at the same $\text{Paco}_2$ for 20 minutes before EEG, anesthetic concentration, and $\text{Paco}_2$ were again measured.

**Results**

**GROUP I**

Increasing the depth of Ethrane–oxygen was associated with a characteristic change in the EEG. Figure 1 shows the pattern of the change in one subject at Paco$_2$ 35–39 torr. As depth increased, spikes (greater than 100 $\mu$V) appeared. With further increases in depth, spike waves (a spike followed by a slow wave lasting as long as a second) occurred, and periods of burst suppression developed (electrical silence one second in duration or longer). Maximum depth was associated with a predominance of spike waves and burst suppression.

A one-minute segment of the EEG that indicated maximal irritability at a given Ethrane concentration and $\text{Paco}_2$ was analyzed for the presence or absence of spike forms of 100 $\mu$V or greater and burst suppression lasting a second or longer. Figure 2 shows the Ethrane concentration and $\text{Paco}_2$ at which one or more spike forms during the one-minute period were observed. Three zones can be identified, i.e., a spike-free area where all the records showed no spikes, a transition area, and a spike-present area where spikes were observed under all conditions of Ethrane and $\text{Paco}_2$. The lines, drawn by eye, separate the zones and indicate the increasing occurrence of spikes with increasing anesthetic depth and decreasing $\text{Paco}_2$.

The occurrence of burst suppression is shown in figure 3. A similar pattern of three
zones was found. Higher Éthane concentrations were needed to produce suppression and \( \text{Paco}_2 \) effect was minimal, as indicated by the lesser slopes of the lines in figure 3, compared with those in figure 2.

In an attempt at quantification, the frequencies of spikes and spike waves and the percentages of the one-minute segments occupied by burst suppression were determined in the 29 records made during normocarbia (\( \text{Paco}_2 \), 35–44 torr, fig. 4). As mean Éthane concentration increased, the frequency of spikes increased, then decreased, with a greater frequency of spike waves and longer isoelectric periods.

In the 16 records made during hypocarbia (\( \text{Paco}_2 \), 45 torr or more) cerebral irritability appeared to be reduced. At mean inspired Éthane concentrations of 1.52 and 2.25 per cent, spikes, spike waves and burst suppression did not occur. At a mean inspired Éthane concentration of 2.6 per cent, the frequency of spikes was 1/min, with neither spike waves nor burst suppression; at a mean inspired Éthane concentration of 3.32 per cent the frequencies of spikes and spike waves were 11.4 and 6.4/min, respectively, and burst suppression occupied 27 per cent of the EEG. Reference to the normocarbic values in figure 4 shows higher frequencies of spikes and spike waves of 7.5 and 3.5/min and a duration of burst suppression of 12 per cent at a mean inspired Éthane concentration of 2.62 per cent. The normocarbic values at a mean inspired Éthane concentration of 3.34 per cent were: spikes, 5.4/min; spike waves 11.0/min; burst suppression 58 per cent.

During hypocarbia (\( \text{Paco}_2 \), 31 torr or less) cerebral irritability appeared to be increased. For example, in 11 observations made at \( \text{Paco}_2 \), 24 torr or less and a mean inspired Éthane concentration of 2.6 per cent, the frequency of spikes was 20/min, the frequency of spike waves was 14/min, and the duration of burst suppression was 25 per cent. At a mean inspired Éthane concentration of 3.36 per cent the frequency of spikes was reduced to 9/min, the frequency of spike waves increased to 26/min, and isoelectric periods occupied 67 per cent of the record (again, see fig. 4 for comparison).

The CO₂ effect on the EEG is demonstrated in another way in figure 5, where reduction in mean \( \text{Paco}_2 \), within an Éthane range of 2.5–2.9 per cent in 26 observations produced increased frequencies of spikes and spike waves and increased the amount of suppression. With inspired Éthane concentrations of 3 per cent or more, the frequency of spikes decreased but the frequency of spike waves and duration of
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used inhalational anesthetics studied to date. Like other halogenated ethers, during light anesthesia (fig. 1) \( \text{\textalpha} \)thane has an EEG pattern characterized by frequencies \(, 9 \) higher than those seen during the administration of diethyl ether \(10\) and cyclopropane. \(11\) With methoxyflurane, for example, high-frequency activity may be present as depth of anesthesia increases, but spike forms are not seen. \(9\) Furthermore, burst suppression appears only at great depths of anesthesia with other halogenated agents. \(12, 13\) In contrast, spike forms and isoelectric periods are not uncommon with \( \text{\textalpha} \)thane under clinical conditions. (MAC for \( \text{\textalpha} \)thane-O\(_2\) is approximately 1.68 per cent. \(14\) The data indicate that anesthetic depth has more influence than low \( \text{Paco}_2 \) in causing the abnormal EEG, although the latter does seem to exert an effect.

We believe that the cerebral irritability that occurs with \( \text{\textalpha} \)thane does not pose major problems for the clinician, for the following

\[ \text{Paco}_2 \text{ (torr)} \]

Fig. 4. The frequencies of spikes and spike waves and the percentages of the EEG occupied by burst suppression in 26 EEG's from 14 individuals at four mean \( \text{\textalpha} \)thane concentrations at a \( \text{Paco}_2 \) range of 33 to 44 torr.

burst suppression increased with reduction of mean \( \text{Paco}_2 \). Little \( \text{Paco}_2 \) effect was seen at \( \text{\textalpha} \)thane concentrations below 2.5 per cent.

\[ \text{Paco}_2 \text{ (torr)} \]

Fig. 5. The frequencies of spikes and spike waves and the percentages of the EEG occupied by burst suppression in 26 EEG's from 11 individuals at four mean \( \text{Paco}_2 \)'s at an inspired \( \text{\textalpha} \)thane concentration of 2.5-2.9%.

\[ \text{Paco}_2 \text{ (torr)} \]

Group II

The effects of addition of 60 per cent nitrous oxide to steady-state \( \text{\textalpha} \)thane at constant \( \text{Paco}_2 \) over an anesthetic range of 1.5-3.4 per cent and a \( \text{Paco}_2 \) range of 21-32 torr were evaluated. Prior to nitrous oxide, the EEG pattern was one of light anesthesia in two subjects, spikes without spike waves or suppression in two subjects, and spike waves and suppression in five subjects. In none of these test circumstances did the addition of nitrous oxide alter the predominant EEG pattern.

Discussion

\( \text{\textalpha} \)thane can produce profound general anesthesia, as well as EEG patterns and occasional motor movements interpreted as representing cerebral cortical irritability. In this respect it differs from all other clinically
reasons. First, studies of cerebral blood flow, cerebral metabolic rate, and patterns of cerebral carbohydrate metabolism during and after deep ether anesthesia in man have failed to reveal evidence of cerebral hypoxia. Second, behavioral patterns in the immediate and delayed (7-14 day) postoperative or poststudy period have resembled those seen with other inhalational anesthetics. Third, the incidence of abnormal movements in the reported clinical series is low. In this study no movements were observed in nonurinized individuals, nor did a multiple-spike seizure pattern occur in the EEG. Fourth, the EEG pattern considered to be indicative of cerebral irritability can be rapidly replaced with a more normal tracing by a reduction in depth of anesthesia.

Anesthetic depth and the modifying effects of 

References


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