

Apnea testing with continuous positive airway pressure for the diagnosis of brain death in a patient with poor baseline oxygenation status

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Abstract

Apnea testing is a key component in the clinical diagnosis of brain death. Patients with poor baseline oxygenation may not tolerate the standard 8-10 min apnea testing with oxygen insufflation through tracheal tube. No studies have assessed the safety and feasibility of other methods of oxygenation during apnea testing in these types of patients. Here, we safely performed apnea testing in a patient with baseline PaO₂ of 99.1 mm Hg at 100% oxygen. We used continuous positive airway pressure (CPAP) of 10 cm of H₂O and 100% oxygen at the flow rate of 12 L/min using the circle system of anesthesia machine. After 10 min of apnea testing, PaO₂ decreased to 75.7 mm Hg. There was a significant rise in PaCO₂ and fall in pH, but without hemodynamic instability, arrhythmias, or desaturation. Thus, the apnea test was declared positive. CPAP can be a valuable, feasible and safe means of oxygenation during apnea testing in patients with poor baseline oxygenation, thus avoiding the need for ancillary tests.

Keywords: Apnea test, brain death, poor baseline oxygenation

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Introduction

Brain death is defined as the irreversible loss of the capacity for consciousness combined with the irreversible loss of all brainstem functions, including the capacity to breathe.^[1] Apnea test is a key component in the clinical diagnosis of brain death. PaO₂ > 200 mm Hg after 10 min of preoxygenation with 100% oxygen is necessary for performing apnea test. To preserve oxygenation during apnea test, it is recommended to place an insufflation catheter through the endotracheal tube close to the level of the carina.^[2] Test is aborted if oxygen saturation measured by pulse oxymetry is <85% for >30 s. Inadequate pretest oxygenation has previously

been associated with failed completion of apnea testing.^[3] Oxygenation was shown to be best maintained with continuous positive airway pressure (CPAP) system when compared with oxygen insufflation method or T-piece system.^[4] No studies have assessed the safety and feasibility of other methods of oxygenation during apnea testing in patients with poor baseline oxygenation status. Here, we safely performed apnea test using CPAP of 10 cm of H₂O in a patient with baseline PaO₂ of 99.1 mm Hg at 100% oxygen. To the best of our knowledge, there is only one reported case of apnea test performed in patient with acute respiratory distress syndrome. A commercially available valve was used to apply CPAP.^[5] For the 1st time, we have mentioned the use of anesthesia machine circle system for applying CPAP during apnea test.

Case Report

A 40-year-old male patient presented to hospital emergency 4 h after gunshot injury to right temporal region. On arrival, he was pulseless. After 30 min of cardiopulmonary resuscitation with repeated cycles

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of adrenaline, return of spontaneous circulation was attained. Airway was secured with an endotracheal tube. Patient required noradrenaline infusion to maintain blood pressure. Computed tomography scan of the head revealed right temporal intraparenchymal hematoma and subdural hematoma with mass effect [Figure 1]. Patient underwent emergency craniotomy for evacuation of clot. Neurological status of the patient remained poor with Glasgow coma scale of 2/10 (intubated) even after 2 days off sedation and paralyzing agents. Pupils were bilaterally 4 mm in size with no response to bright light. Corneal, pharyngeal and gag reflexes were absent. Oculovestibular reflex was absent. Oculocephalic reflex was not performed due to the presence of a cervical collar. Patient was euvolemic, with nasopharyngeal temperature of 37.4°C. Systolic blood pressure was maintained >100 mm Hg with noradrenaline infusion at 0.2 µg/kg/min and vasopressin infusion at 0.03 units/min.

Apnea test was planned. After ventilating the patient for 10 min with 100% oxygen, his baseline arterial blood gas (ABG) revealed pH of 7.36, PaCO₂ of 43.3 mm Hg and PaO₂ of 99.1 mm Hg. Apnea test was performed with CPAP of 10 cm of H₂O and 100% oxygen at the flow rate of 12 L/min using Kimura Siesta 21 – PS anesthesia machine as shown in Figure 2. The circle system with reservoir bag was used and adjustable pressure limiting valve was manually adjusted to generate a constant CPAP of 10 cm of H₂O as shown by the manometer. No respiratory movements were noticed during 10 min of apnea testing. There was no hemodynamic instability, arrhythmias or desaturation. Lowest oxygen saturation recorded by pulse oxymeter was 89%. ABG at the end of 10 min showed pH of 7.14 with PaCO₂ of 75.3 mm Hg and PaO₂ of 75.7 mm Hg. Apnea test was positive and the patient was declared brain dead.

Discussion

Apnea test is one of the main steps in neurological determination of death. The test is considered positive if respiratory movements are absent and arterial PaCO₂ is ≥60 mm Hg (or 20 mm Hg increase over baseline normal PaCO₂). Test needs to be aborted if systolic blood pressure decreases to <90 mm Hg or if patient develops significant arrhythmias or if there is significant oxygen desaturation. After preoxygenating with 100% oxygen for 10 min, it is recommended to insufflate 100% oxygen at 6 L/min through the endotracheal tube, using a catheter, to preserve oxygenation.^[2] This method of oxygenation is not free of risk as there are reports of tension pneumothorax leading to cardiac arrest when apnea test was performed.^[6] In a study, comparing three oxygenation systems, application of 10 cm of H₂O of CPAP at 100% oxygen flow of 12 L/min was shown to decrease PaO₂ by 22.4 ± 76 mm Hg as compared to 99.1 ± 158 mm Hg with oxygen insufflation method and 91.6 ± 133 mm Hg with T-piece system after 10 min. The findings were consistent with that in our patient where PaO₂ decreased by 23.4 mm Hg at the end of 10 min. In a case report by Hocker *et al.*, apnea test was successfully performed in a patient with severe acute respiratory distress syndrome after applying a lung recruitment maneuver. CPAP of 20 cm of H₂O was applied during the test.^[5] Our patient was on two vasopressors and hypotension is common during lung recruitment maneuver^[7] and also during apnea test itself.^[8] The maneuver was also shown to have adverse effects on cerebral hemodynamics and metabolism in patients with cerebral injury.^[9] Hence, we didn't perform lung recruitment maneuver. At the end of 10 min of test, PaCO₂ reached 75.3 mm Hg, with a rise of 32 mm Hg from baseline. The rise was consistent with the findings of Frumin *et al.*, where they found an average rise of 3 mm Hg/min of apneic oxygenation.^[10] Arterial pH dropped to

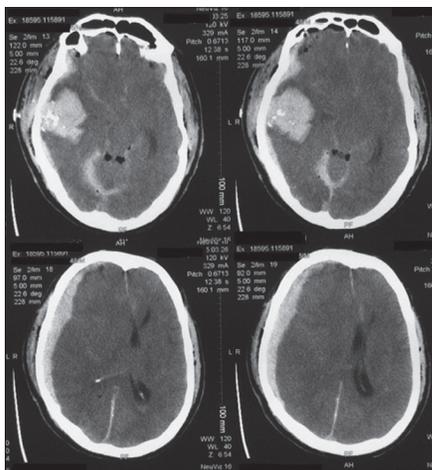


Figure 1: Computed tomography scan of head showing right intraparenchymal and subdural hematoma with mass effect



Figure 2: Circle system of anesthesia machine with reservoir bag, used to generate constant continuous positive airway pressure of 10 cm of H₂O

7.14. Criteria for a positive test were met and the patient was declared brain dead.

Continuous positive airway pressure valve, as used in the case report by Hocker *et al.*, is not readily available in resource limited places. All the modern intensive care unit ventilators have apnea backup ventilation in CPAP mode, making it not feasible during apnea testing. For the first time in medical literature, we are reporting the use of an anesthesia machine circle system for application of CPAP during apnea test. It is simple to perform, is easily available and adds no financial burden to the patient. Application of lung protective strategy with low tidal volume ventilation and use of CPAP during apnea test in potential organ donors with beating heart increased the number of eligible and harvested lungs when compared with conventional ventilatory strategy with apnea test performed by disconnecting the ventilator.^[11]

Ancillary tests cannot replace neurological examination and there is potential for false positive results.^[2] In this patient, application of CPAP during apnea test helped to avoid ancillary tests. Performance of ancillary tests would require transport of this hemodynamically unstable patient with poor baseline oxygenation to radiology suit. Moreover, these tests are not readily available in resource constrained countries like ours.

Continuous positive airway pressure can be a valuable, feasible, and safe means of oxygenation during apnea testing in patients with poor baseline oxygenation, thus avoiding the need for ancillary tests. There is a need for randomized studies to evaluate the safety and feasibility of apnea test using CPAP in patients with poor baseline oxygenation status.

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