

A Randomized Study of Comparison of Intravenous Dexmedetomidine and Intravenous Esmolol to Attenuate the Cardiovascular Responses to Laryngoscopy and Endotracheal Intubation

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Abstract

Aims: Objective is to compare the efficacy of intravenous Dexmedetomidine and Esmolol in attenuating the cardiovascular pressor responses to laryngoscopy and endotracheal intubation. **Method:** Study was done on 60 adults, ASA grade I or II normotensive patients, undergoing elective surgery under general anaesthesia and willing to participate. These patients were randomly allocated into either group E (Esmolol) or D (Dexmedetomidine). Group 'D', patients were given intravenous Dexmedetomidine infusion 1 mcg/kg over 10 minutes, 3 minutes before start of laryngoscopy. Group 'E', patients were given intravenous Esmolol 1.5 mg/kg 2 minutes before start of laryngoscopy. All patients were premedicated, induced and intubated using Thiopentone and Succinyl Choline as per the protocol.

Index terms— laryngoscopy, intubation, Esmolol, hemodynamic, response, dexmedetomidine.

1 Introduction

Laryngoscopy and endotracheal intubation is accompanied with significant increases in heart rate and arterial blood pressure (1), and can lead to adverse outcome. These cardiovascular responses are transient occurring at around 30 seconds after intubation and can last up to 10 minutes (2). The sympathetic stimulation is also associated with dysrhythmias (3).

These cardiovascular responses to sympathetic stimulation although of short duration and are of little consequence in healthy individuals, but serious complications can occur in patients with underlying coronary artery disease (4) reactive airways, (5) or intracranial neuropathology (6).

These reflexes are mediated by the cardioaccelerator nerves and sympathetic system. This response includes wide-spread release of norepinephrine from adrenergic nerve terminals and secretion of epinephrine from the adrenal medulla (7).

Esmolol is an ultra-shortacting, beta-adrenergic receptor antagonist with efficacy to provide hemodynamic stability during laryngoscopy and tracheal intubation without side-effects. (8) It inhibits Beta-1 receptors of myocardium thus attenuating positive chronotropic, to very less extent it also inhibits Beta 2 receptors of smooth muscles of vascular walls thus attenuating positive inotropic effects (9) Dexmedetomidine is an imidazole derivative and highly selective central alpha₂adrenergic receptor agonist (10). Alpha-2agonists produce hyperpolarization of noradrenergic neurons and suppression of neuronal firing in the locus coeruleus leads to decreased systemic noradrenalin release results in attenuation of sympathoadrenal responses. Although mostly used as sedative during anaesthesia, it can provide hemodynamic stability during laryngoscopy and tracheal intubation (11).

2 II.

3 Method

Study Population: 60 adult ASA grade I or II normotensive patients, undergoing elective surgery under general anaesthesia and willing to participate was the study population.

Study Design: It is a prospective randomized study. The approval for the study was obtained from the Institutional Ethics Committee.

4 Inclusion Criteria

Male and female of age group between 25 to 65 years. Undergoing elective surgery under general anesthesia. Weight 40 kg to 90kg. Resting systolic blood pressure less than 140 mmHg and diastolic pressure less than 90 mmHg. American Society of Anaesthesiologist Grade I and II.

5 Exclusion Criteria

Ischemic heart diseases or ECG abnormalities indicating ischemic heart diseases. Patients with any overt cardiac, renal, pulmonary and liver diseases. Hypertensive patients. Any Patients with history of dyspnoea on exertion of grade III or more as per NYHA guidelines. Obesity (weight more than 90kg). Pregnancy. ASA grade III or IV patients. Anticipated difficult intubation. Any contraindication of Dexmedetomidine and Esmolol.

6 a) Methodology

7 Pre-Operative Investigations and Assessment

A preoperative evaluation was carried out in all patients with demographic data like age, gender, weight and detailed clinical history, physical examination including, associated medical co-morbidities, and current medications. Blood pressure was measured at three occasions at least 1 hour apart to confirm that it fulfils the selection criteria. All routine and relevant investigations such as complete blood count, renal function test (serum electrolytes, serum creatinine, and blood urea levels), urine routine and microscopy, electrocardiogram, chest X-ray were carried out for all patients. The factors indicating difficult intubation on clinical examination were ruled out.

8 Pre-Operative Management

All patients received Tablet Pantoprazole 40 mg at night before surgery and 3 hours before surgery and Tablet Alprazolam 0.5 mg was given night before surgery. A 20G intravenous cannula was secured on non-dominant hand in appropriate vein in wards and intravenous fluid Ringers Lactate 500 ml as maintenance was started about 3 hours prior to surgery. About one hour prior to surgery, baseline readings were taken for pulse rate and blood pressures (Systolic, Diastolic and Mean) and were considered as preoperative baseline reading.

These patients were be randomly allocated in to either group E (Esmolol) or D (Dexmedetomidine). Once group was decided, blinding was not maintained.

9 In Operation Theatre

In the preoperative area, monitoring of hemodynamic parameters such as Heart Rate, Noninvasive blood pressure monitoring (NIBP), oxygen saturation (SpO₂) and Electrocardiography (ECG) was done. Five ECG leads were placed on chest and Lead II, Lead aVL and Lead V were continuously observed on monitor. In operation theatre monitoring of these parameters were continued. All the 3 groups received sedation with Intravenous Midazolam 0.02 mg/kg and Fentanyl 2 mcg/kg about 15 minutes before induction. Preoxygenation with 100% oxygen by using facemask in closed circuit to achieve oxygen saturation (SpO₂) of 98 -99% was done.

? For Group 'D', patients were given intravenous Dexmedetomidine infusion 1 mcg/kg over 10 minutes, 3 minutes before start of laryngoscopy. ? For Group 'E', patients were given intravenous Esmolol 1.5 mg/kg 2 minutes before start of laryngoscopy.

Induction of anaesthesia was done with Intravenous Thiopentone 5mg/kg body weight given slowly till loss of eyelash reflex is seen. Then intravenous Succinylcholine was given in dose of 2 mg/kg. Then facemask ventilation was done till twitches disappears and adequate relaxation obtained. Direct laryngoscopy was conducted by the same anaesthesia consultant for all cases, using standard McIntosh blade and an appropriate size cuffed endotracheal tube lubricated with non-anaesthetic jelly and was inserted in single attempt and cuff will be immediately inflated with air to a pressure of 25 cm of water.

After confirming bilateral equality of air entry in lungs by auscultation, the endotracheal tube was secured with the adhesive tape. Ventilation was done by IPPV on ventilator. Ventilatory setting was set to provide tidal volume of 8-10 mg/kg and respiratory rate 14/minute for 10 minutes. No noxious stimulus or surgical incision was applied over 10 minutes after intubation.

Supine position was maintained. Anaesthesia was maintained using 50% nitrous oxide and 50% oxygen with Isoflurane (MAC-1.0). Hemodynamic parameters were monitored as follows: Heart rate (HR), Systolic blood pressure (SBP), Diastolic blood pressure (DBP), Mean Arterial Pressure (MAP) by non-invasive technique.

The intervals for these measurements were:

1. Baseline (taken half an hour prior to anaesthesia)
2. Before sedation
3. After induction but before intubation
4. Immediately after intubation
5. Thereafter at 1, 2, 3, 4, 5 and 10 minutes.

After this monitoring for 10 minutes postintubation, further operative and anaesthetic procedure were continued as per plan. For comparison of categorical variables chi-square test was used.

III.

10 Results

Comparison of patient variables such as age, gender and weight shows that there is no statistically significant demographical difference between group D and E. (Table ??) MAP was lower in Group D as compared to Group E. There was no statistically significant difference at baseline, before sedation or after induction. Thereafter DBP was statistically significant lower in group D except at 10 minutes after intubation, where difference was not statistically significant. (Table 5)

11 Discussion

There is well recognised, hemodynamic response which is characterized by tachycardia and hypertension due to manipulation in the area of the larynx, during laryngoscopy and endotracheal intubation. Stimulation of mechanoreceptors in the pharyngeal wall, epiglottis and vocal cords, is thought to be the cause for this hemodynamic response.

Cardiovascular pressor response following laryngoscopy and tracheal intubation has been investigated extensively for a long time and reported these changes. (12). Myocardial ischemia might occur during the induction-intubation sequence in patients with coronary artery disease. Intraoperative ischemia has been associated with a high rate of perioperative myocardial infarction. (13) During procedure like direct laryngoscopy involving severe sympathetic stimuli prevention of tachycardia, hypertension and rise in total oxygen consumption may prove beneficial in patients with limited cardiac reserve (14).

Esmolol is effective, in a dose-dependent manner, in the attenuation of the sympathomimetic response to laryngoscopy and intubation. Shrestha et al (15) noted that doses of Esmolol higher than 1.5 mg/kg did not completely prevent the pressor response to laryngoscopy and intubation. Sum et al (16) has also found a similar effect in addition to increase in intracranial pressure.

Dyson et al (17) noted that Esmolol in doses 1 mg/kg was insufficient to control the increase in systolic blood pressure compared to 1.5 mg/kg and 2 mg/kg which controlled both systolic blood pressure and heart rate, but 2 mg/kg dose produced significant decreases in systolic blood pressure.

Miller et al (18) in their study have reported that 100 mg of single bolus dose of Esmolol was effective for controlling the hemodynamic response to tracheal intubation in a Canadian multicentre trial.

Study done by Sanjeev Singh et al (19) comparing Esmolol also showed significant increase in Heart Rate after intubation and remained significantly high at 3 and 5 mins. They also found increase in SBP, DBP and MAP from the baseline in after Esmolol at 1 min with onward decreases at 3 and 5 min respectively after intubation. Kindler et al (20) also found that Esmolol administration before laryngoscopy was insufficient to control HR and SBP after intubation. Oxorn et al (21) concluded that Esmolol in bolus doses of 100 mg and 200 mg affects solely the chronotropic response in a significant manner, more so than hypertensive response.

Dexmedetomidine is a highly selective and specific alpha two adrenergic agonist which produces its action by decreasing the catecholamine release from Mean DBP(mmHg) Reddy et al (28) observed that Esmolol was not as effective as Dexmedetomidine in attenuating the hypertensive response to tracheal intubation. In fact, after use of Esmolol for intubation a significant increase in SBP was observed and compared to Dexmedetomidine the increase in SBP was greater and more significant in this study.

Srivastava et al (29) also found Systolic blood pressure values were statistically significantly lower in the Dexmedetomidine after induction and all time observation of intubation, when compared with Esmolol to the baseline values. They also observed statistical significant increase in Blood pressure after intubation at 1, 2 and 3 min only after intubation. Although Esmolol was considered to have significant effect on both tachycardia and hypertensive response following ET intubation, Unlike our study, Liu et al (30) who used Esmolol infusion to control hemodynamic responses associated with intubation, found significant decreases in a SBP prior to induction and post-intubation, compared to the placebo group. This could be because in their study patients received infusion rather than bolus like our study.

In present study, pretreatment with Esmolol 1.5 mg/kg attenuated, but did not totally obtund, the cardiovascular response to tracheal intubation after induction of anesthesia and these findings are similar with previous studies. α -adrenoceptor blockade minimizes increase in HR and myocardial contractility by attenuating the positive chronotropic and inotropic effects of increased adrenergic activity. But it failed to effectively attenuate hypertensive response to intubation.

Our study demonstrated that the use of Dexmedetomidine was more effective than Esmolol in decreasing the cardiovascular responses to laryngoscopy and intubation.

V.

12 Conclusion

In Normotensive patients requiring general anesthesia with intubation, after induction with Fentanyl and Thiopentone, and Succinylcholine as muscle relaxant, we found that intravenous Dexmedetomidine 1ug/kg is better drug to attenuate hemodynamic response to laryngoscopy and intubation as compared to intravenous Esmolol 1.5mg/kg.

Figure 1: ?

No1

Variables	GROUPS		p-Value
	Group D	Group E	
Age	34.8 ± 12.494	37.6 ± 12.653	0.392
Weight	65.4 ± 9.103	63.93 ± 7.856	0.506
Gender	Male 19	19	1.000
	Fenale 11	11	

Figure 2: Table No . 1 :

2

*statistically significant
SBP was lower in Group D as compared to Group E. There was no statistically significant difference at baseline, before sedation or after inductionThereafter SBP was statistically significant lower in group D. (Table 3)

Figure 3: Table 2)

No3

*statistically significant DBP was lower in Group D as compared to Group E. There was no statistically significant difference at baseline, before sedation or after induction Thereafter	DBP was statistically significant lower in group D except at 10 minutes after intubation, where difference was not statistically significant. (
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Figure 4: Table No . 3 :

4

*statistically significant

[Note: A]

Figure 5: Table 4)

5

*statistically significant HR in Group D and E	SBP in Group D and E
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[Note: DBP in Group D and EMAP in Group D and E Graph No. 3: Comparison of Mean Graph No. 4: Comparison of Mean IV.]

Figure 6: Table 5 :

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.2 Declarations

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.3 Conflict of interest: None

Ethical approval: Approval was obtained from hospital's ethical and scientific committee.

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12 CONCLUSION

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