INHALATIONAL ANESTHETICS

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Outline

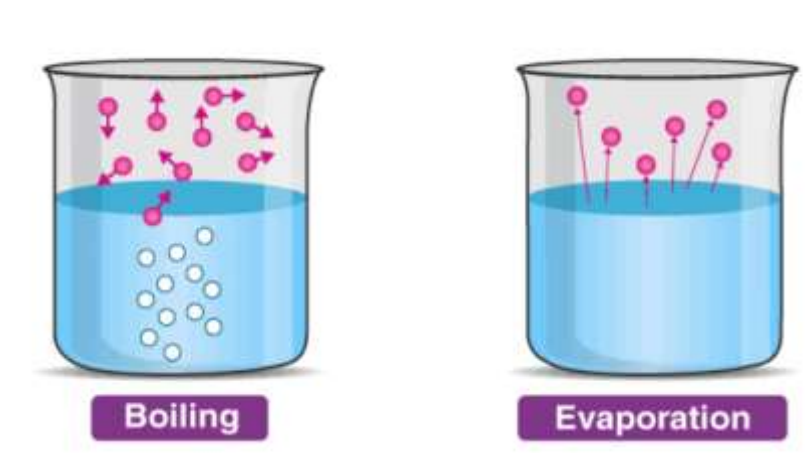
- Introduction
- Pharmacokinetics
- Pharmacodynamics
- Malignant hyperthermia

INTRODUCTION

What are we talking about??

What is it?

- What is difference between solids, liquids, and vapor (gas)?
- Heat consumption.
- Factors affecting rate of vaporization:
  - Temperature.
  - Surface area.
  - Pressure.
  - Wind speed.



Two types of vaporisation

Can you name routes of administration of different anaesthetic agents?

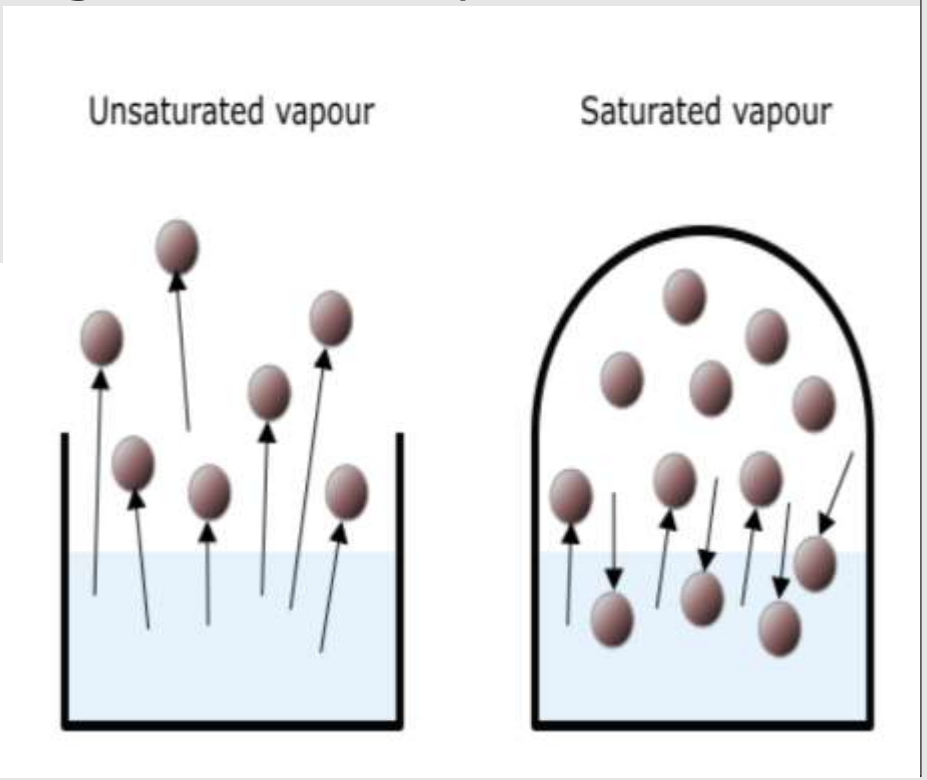
What is it?

- Liquids with tendency to vaporise. Liquids at room temperature, which easily vaporise and have a low boiling point. Delivered through respiratory system (Inhaled).
- Usually, halogenated hydrocarbons or ethers.
- Delivered to the patent via a *vaporizer.*
- *Critical temperature*: temperature above which a substance can not be liquified (only gas form). Below this liquids co-exist with their gas form (vapor).
- Ex. Water: 374 C.

Saturated Vapour Pressure (SVP)

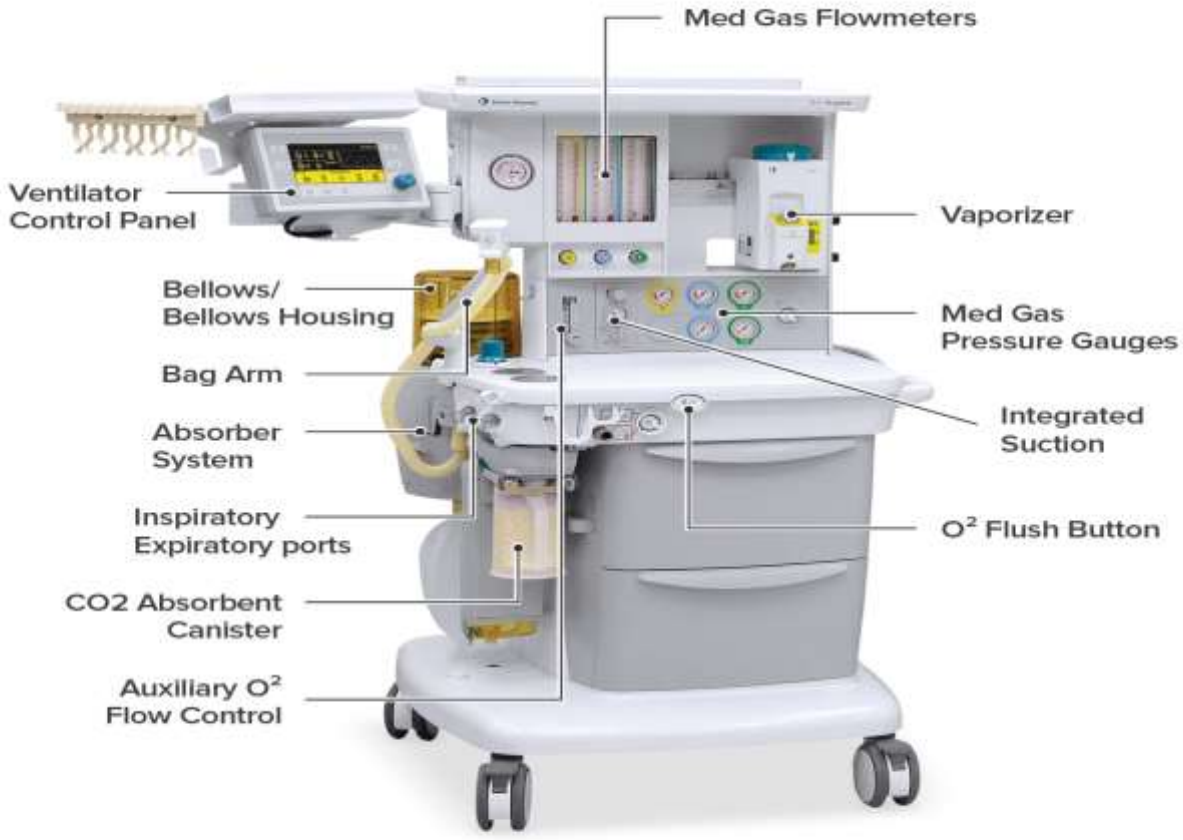
- At any given temperature, there will be a dynamic equilibrium where the number of molecules entering the liquid phase equals those leaving it and the vapour is therefore saturated.
- SVP is the pressure exerted by the vapour phase of a substance when in equilibrium with the liquid phase.

Agent	Boiling point (°C)	SVP at 20°C (kPa)
Desflurane	23	89
Sevoflurane	59	21
Isoflurane	49	32
Halothane	50	33

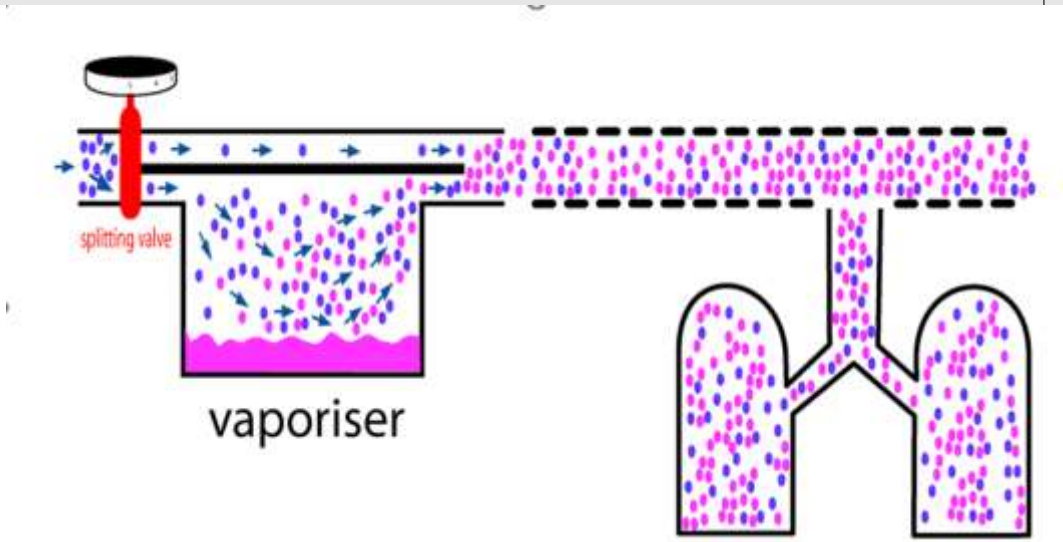


PHARMACOKINETICS

What is it?



GE Aespire Components and Controls



Inhalational Anesthetic Agents

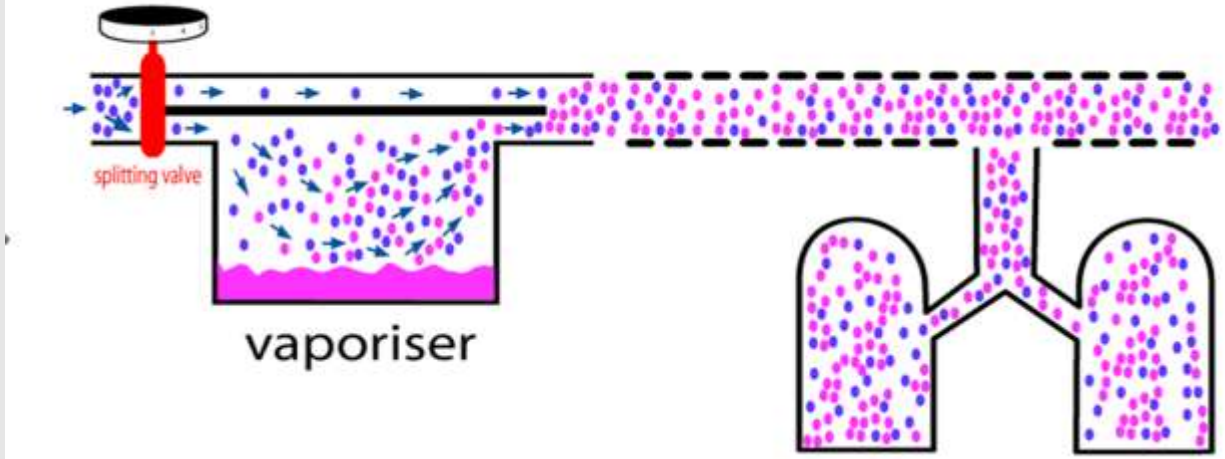
Inhalational anesthesia refers to the delivery of *gases or vapors* from the respiratory system to produce or maintain anesthesia

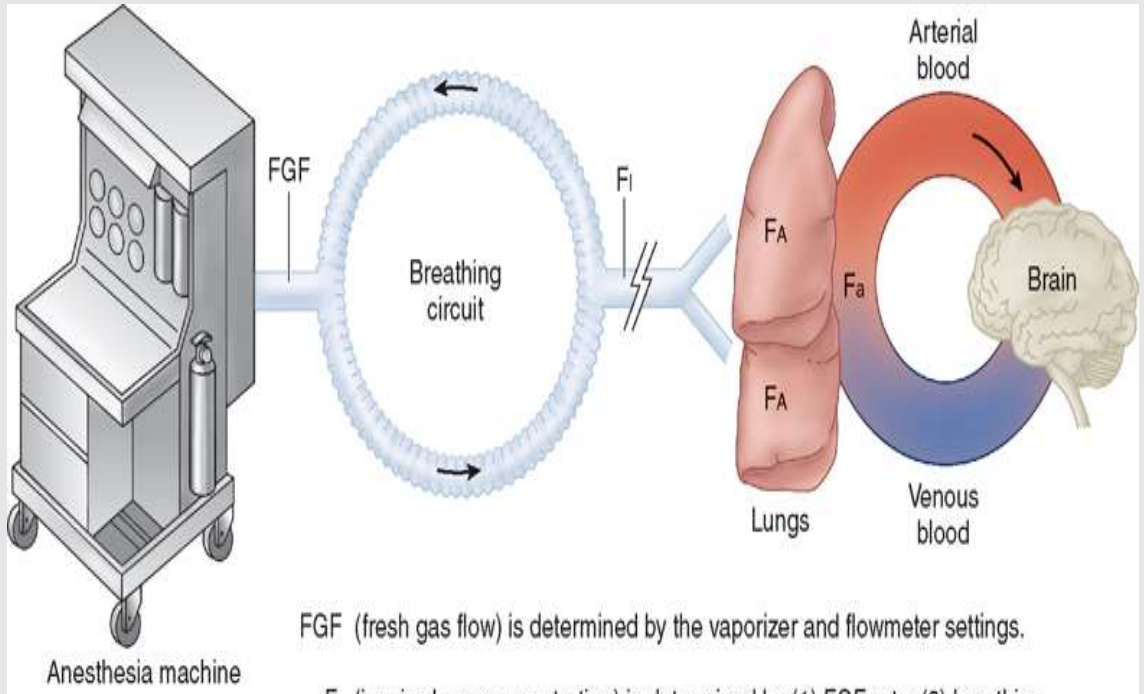
Exposure to the pulmonary circulation allows build up of concentration in arterial blood. It is slower than IV induction.

Uptake and Distribution

The depth of general anesthesia depends on the partial pressure (or gas fraction) exerted by the inhalational agent in the patient brain (b).

p_I -> p_A -> p_a -> p_b





FGF (fresh gas flow) is determined by the vaporizer and flowmeter settings.

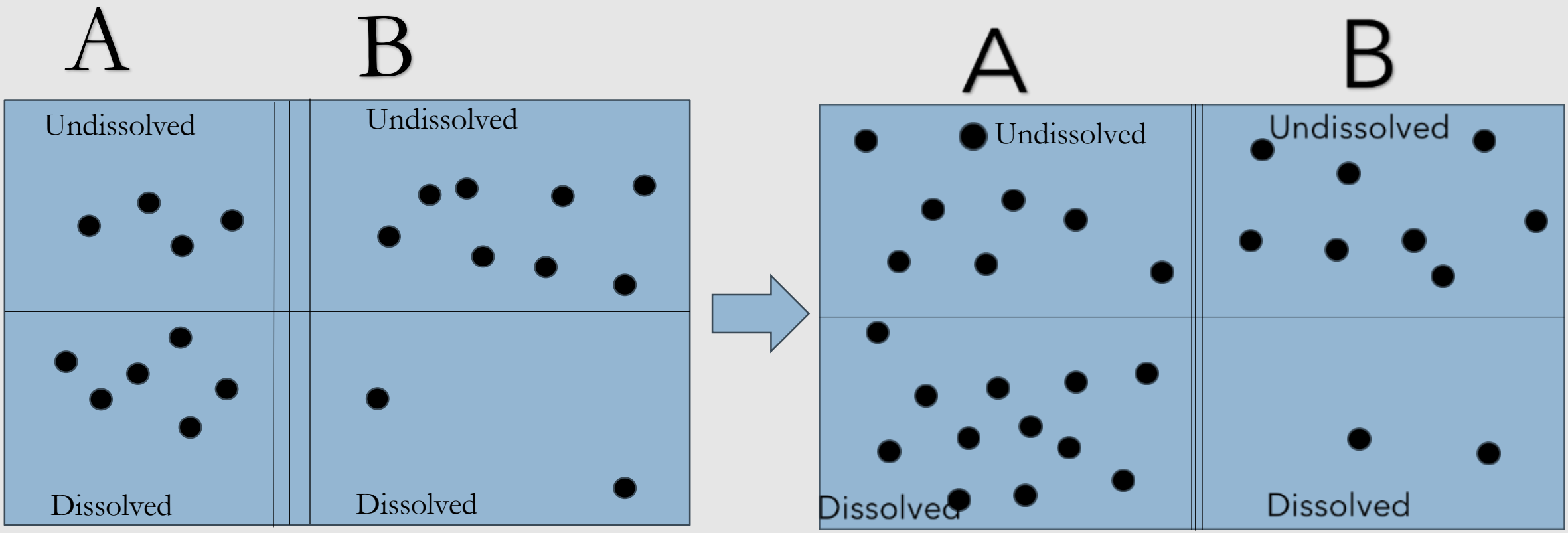
FI (inspired gas concentration) is determined by (1) FGF rate; (2) breathing-circuit volume; and (3) circuit absorption.

FA (aveolar gas concentration) is determined by (1) uptake (uptake = λb/g x C(A-V) x Q); (2) ventilation; and (3) the concentration effect and second gas effect:
a) concentrating effect
b) augmented inflow effect

Fa (arterial gas concentration) is affected by ventilation/perfusion mismatching.

Source: Butterworth JF, Mackey DC, Wasnick JD: *Morgan & Mikhail's Clinical Anesthesiology*, 5th Edition: www.accessmedicine.com

Partition Coefficients



Solubility of the agent in compartment (tissue) A is more than tissue B

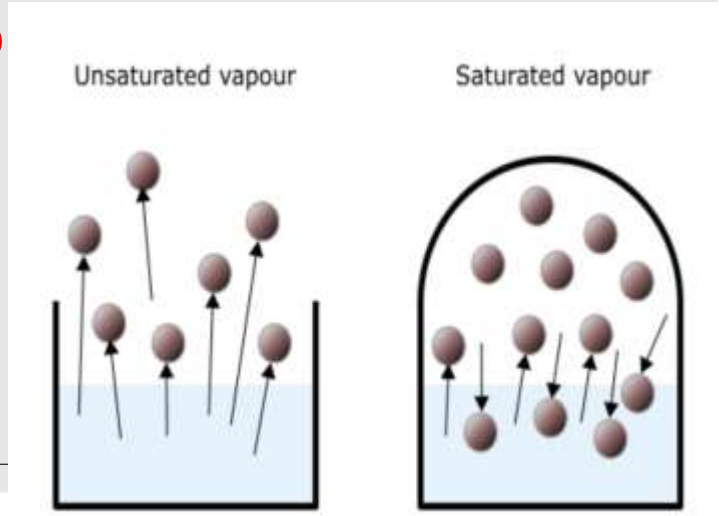
Partition Coefficients

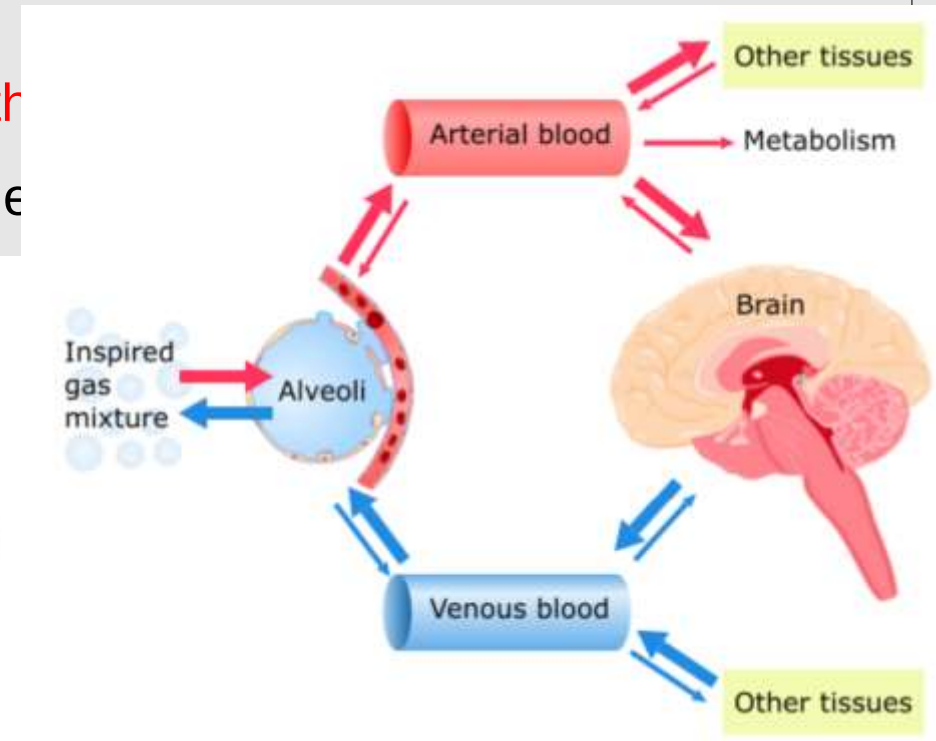
- Relative solubilities of an anesthetic in air, blood, and tissues are expressed as partition coefficients.

- Each coefficient is the ratio of the concentrations of the anesth

vapour in each of two phases at steady state. Steady state is de

equal partial pressures in the two



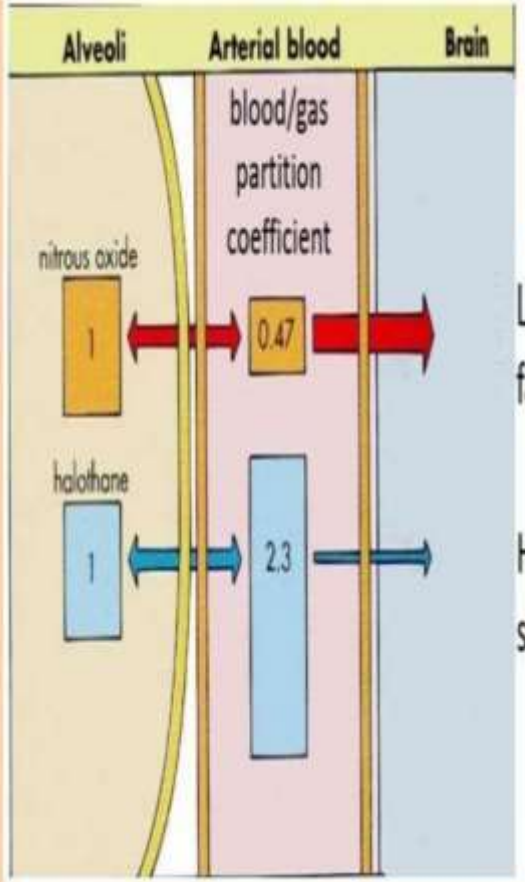


Blood:Gas partition coefficient (λb/g)

- Blood compared to alveoli.

High solubility in blood	Low solubility in blood
High blood/gas partition coefficient	Low blood/gas partition coefficient
- Slow induction and recovery	- Rapid induction and recovery
- Slow adjustment of depth of anaesthesia	- Rapid adjustment of depth of anaesthesia
(Blood acts as a reservoir (store) for the drug so it doesn't enter or leave the brain readily until the blood reservoir is filled)	(Because the blood reservoir is small the anaesthetic is available to pass into/out of the brain quicker)

Agent	Blood:gas coefficient at 37°C
Desflurane	0.45
Sevoflurane	0.65
Isoflurane	1.4
Halothane	2.3
N_2O	0.47

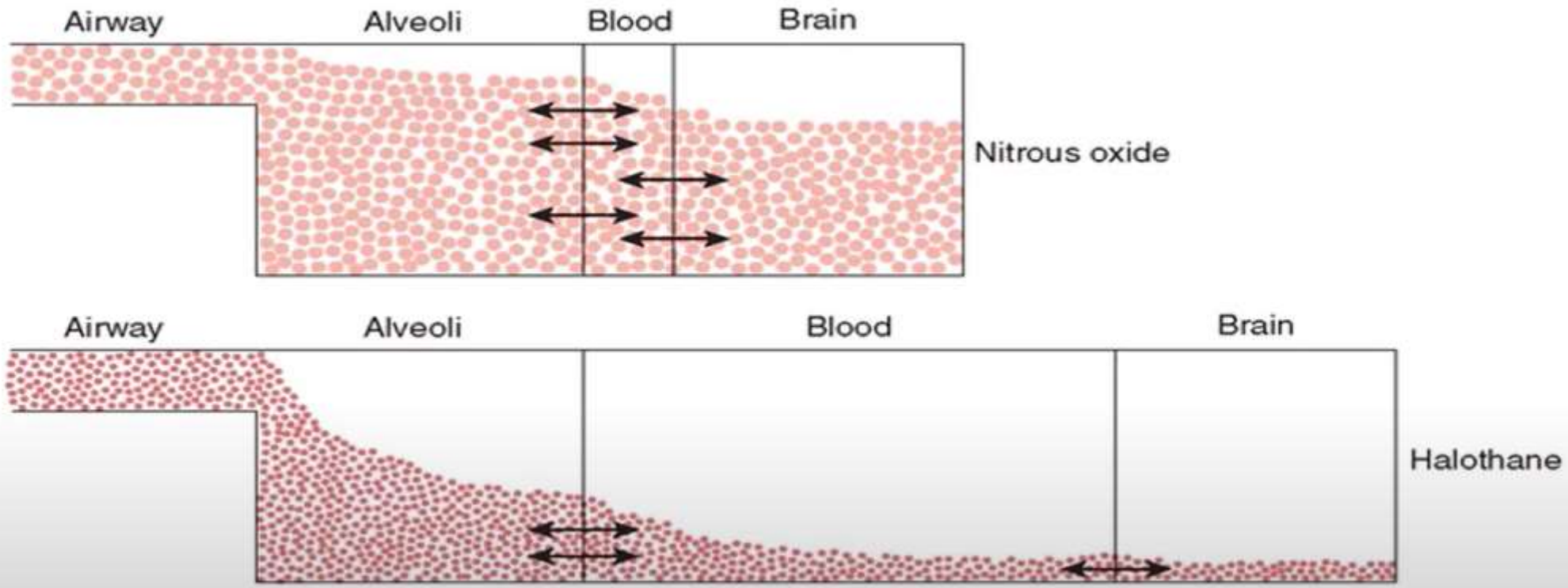


MORE POTENT?

LOW solubility in blood= fast induction and recovery

HIGH solubility in blood= slower induction and recovery

Blood:gas partition coefficient



Source: Trevor AJ, Katzung BG, Kruidering-Hall M, Masters SB: *Katzung & Trevor's Pharmacology: Examination & Board Review*, 10th Edition: www.accesspharmacy.com

Oil:Gas partition coefficient

- Brain compared to blood.
- related to lipid solubility and potency.
- Potency is measured by MAC.

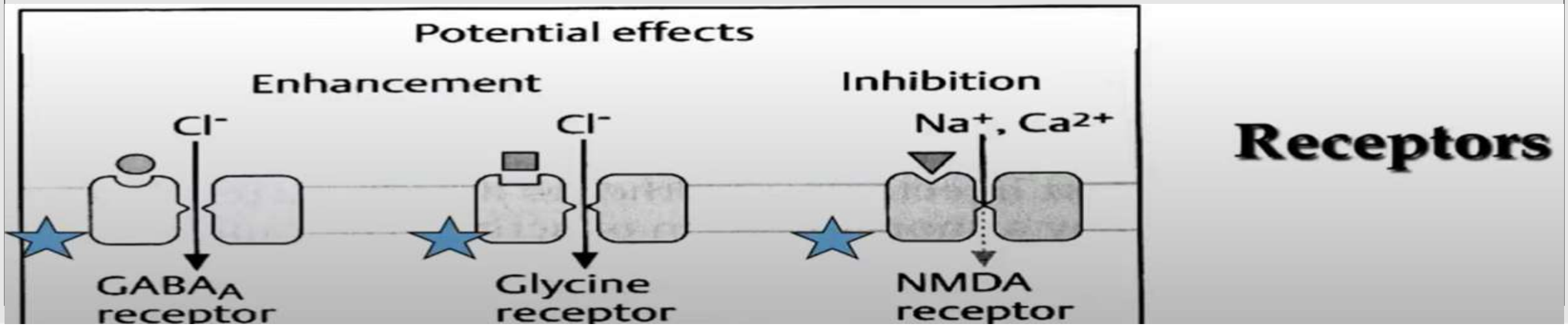
Agent	MAC (%)
Desflurane	6.6
Sevoflurane	2.0
Isoflurane	1.1
Halothane	0.75
N_2O	104

MOA

- Mechanism of action is complex, and agents act at multiple specific target sites; likely a combination of membrane proteins, receptors and channels. (Multisite Hypothesis).

- Impair neuronal activity in different parts of the brain, namely the fronto-parietal cortices and the thalamus.

- Shown to affect receptors of GABA-A (+), glycine (+), NMDA (-), nACh (-), 5-HT3 (-), Glutamate (-).



Metabolism of inhaled anesthetics II

Agent	% metabolized
Halothane	20
Sevoflurane	2-5
Enflurane	2.4
Isoflurane	0.2
Desflurane	0.02
Nitrous Oxide	0.004

Table 15-1. Barash 4th Edition. p378.

Minimum Alveolar Concentration

- In 1963, Merkel and Eger made the observation that the anesthetic effects of volatile agents are directly correlated with their alveolar concentrations and coined the term "minimal alveolar concentration" (MAC) as a means of measuring anesthetic potency.

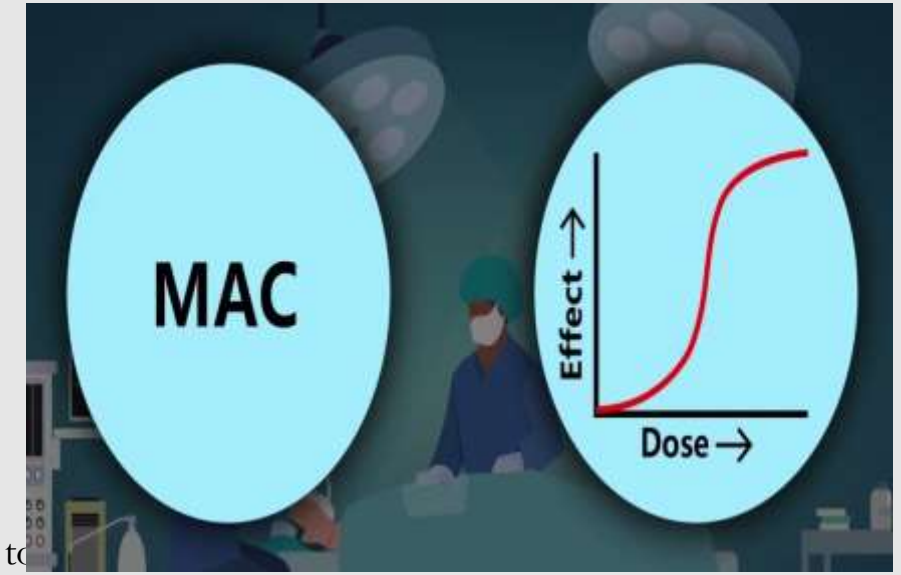
- Partial pressure of gas in the alveolus which will equilibrate with concentration in the brain is the most important factor.

- **Minimal alveolar concentration (MAC) of inhalational**

agent that prevent movement in 50% of the patients in response

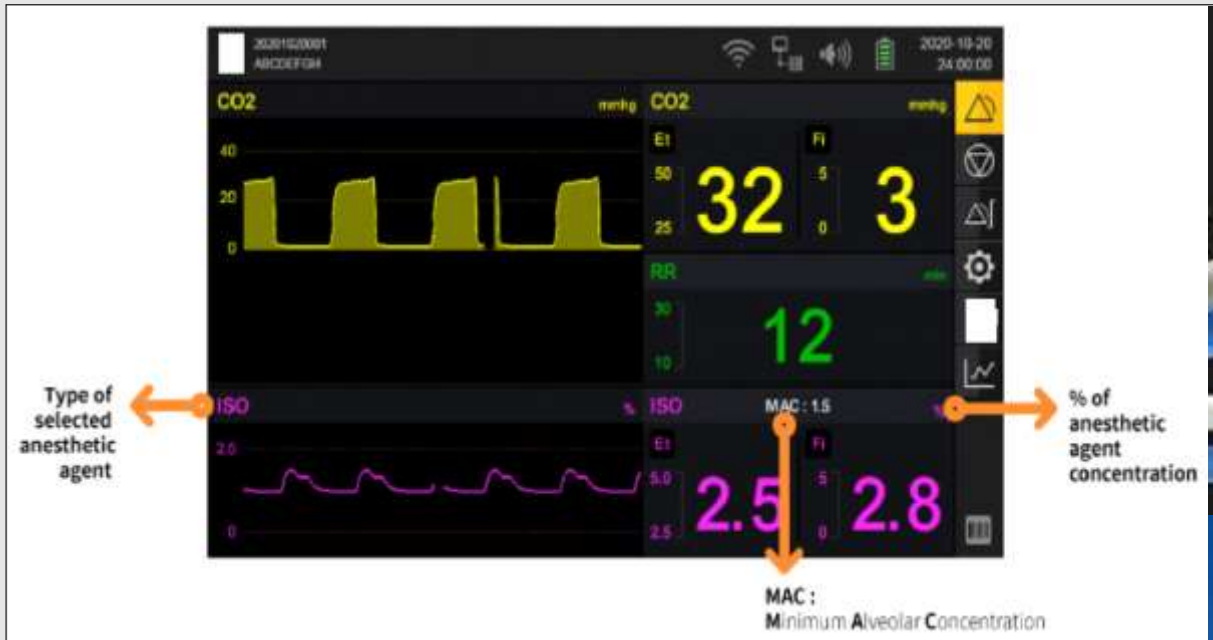
to surgical stimulation (skin incision) at body temperature (37c) and

1 atmospheric pressure (760 mmHg).



- Equivalent to ED_{50}

- It provides a standard way of estimating anesthetic depth and comparing one agent to


CO2
mmhg
CO2
mmhg
40
20
0
E1
Fi
50
25
32
5
0
3
RR
30
10
12
ISO
%
ISO
MAC : 1.5
%
2.0
0
E1
Fi
5.0
2.5
2.5
2.8
5
0
Type of selected anesthetic agent
% of anesthetic agent concentration
MAC :
Minimum Alveolar Concentration


NIHON KOHDEN
NIHON KOHDEN
Multigas Unit
CAUTION

Minimum Alveolar Concentration

- MAC values are additive between different inhalational agents

- It is inversely proportional to potency (lipid solubility).
  - MAC 0.3 – 0.4 = MAC-awake = awakening form anesthesia in absence of other agents
  - MAC 1.3 = ED95 = blunting of response in 95% of patients
  - MAC 1.5 = MACBAR Blocking of adrenergic response to surgical stimulus

Minimum Alveolar Concentration

The rationale for this measure of anesthetic potency is,

- alveolar concentration can be *easily measured*
- near *equilibrium*, alveolar and brain tensions are virtually equal

Factors which support the use of this measure are,

- MAC is invariant with a variety of noxious stimuli
- individual variability is small
- sex, height, weight & anaesthetic duration do not alter MAC
- doses of anaesthetics in MAC's are additive

Factors affecting MAC

PHYSIOLOGIC & PHARMACOLOGIC FACTORS AFFECTING MAC

Increase in MAC:-

- Hyperthermia
- Hypernatraemia
- Drug induced elevation of CNS catecholamine stores
- Chronic alcohol abuse & chronic opioid abuse
- Increases in ambient pressure (experimental)
- Cyclosporine
- Excess pheomelanin production(red hair)

Decrease in MAC:-

- Hypothermia & Hyperthermia (if >42◦ C)
- Hyponatraemia
- Drug induced decrease in CNS catecholamine level
- Increasing age (6% decrease/decade)
- Preoperative medication
- Hypoxaemia (PaO_2< 38mmHg)
- Hypotension(<40 mm hg- MAP)
- Anaemia (Haematocrit< 10%)
- Pregnancy (progesterone)
- Postpartum(returns to normal in 24-72 hrs)
- CNS depressant drugs – Opioids,Benzodiazepines TCA's etc.
- other drugs–lithium, Lidocaine,Magnesium
- acute alcohol abuse
- Cardiopulmonary bypass

Advantages of inhalational anesthesia

- Less traumatic (children, needle phobic adults, adults with learning disability).
- Difficult IV access.
- Spontaneous ventilation and airway tone.
- Titration of dept of anaesthesia.
- Bronchodilatation.
- Brief anaesthesia.

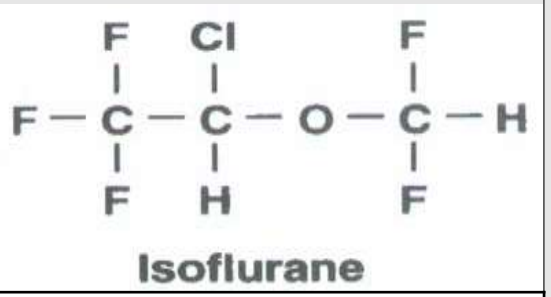
Disadvantages of inhalational anesthesia

- Smell.
- Airway irritation.
- Excitation phase of anaesthesia.
- Cardiac and respiratory depression.
- Theatre pollution.
- Malignant hyperthermia.

Ideal inhalational agents

- Low blood:gas partition coefficient allowing rapid induction
- Non-flammable
- Non-pungent (or odourless)
- Non-irritant to the airway
- Non-cardiac depressant
- Non-respiratory depressant
- Non-toxic to liver and kidneys

Isoflurane



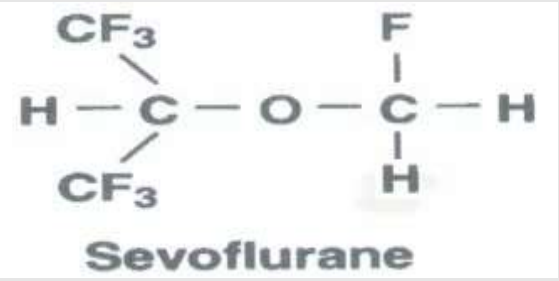
Isoflurane

- Haloginated methyl ethyl ether.
- Nonflammable, pungent (not used for induction).

Physical properties	
MAC	1.2 %
Vaporiser concentration range	0-5%

Physiological effects	
CNS	↑ CBF, ICP at >> 1 MAC : reversed by hyperventilation ↓ Cerebral metabolic oxygen requirement
CVS	Most significant reduction in SVR → ↓ BP
Respiratory	↓ Minute ventilation, Blunt the normal ventilatory response to hypoxia and hypercapnia, Irritate upper airway reflex, a good bronchodilator
Neuromuscular	Relaxes skeletal muscle
Renal	↓ Renal blood flow: ↓ GFR and U/O
Hepatic	↓ Total hepatic blood flow

Sevoflurane



- Fluorinated methyl-isopropyl ether.
- Non pungency and relatively low MAC → most common for inhalational induction.

Physical properties	
MAC	2.0%
Vaporiser concentration range	0-8 %

Physiological effects	
CVS	Mildly depress myocardial contractility ↓ Systemic vascular resistance: ↓ arterial BP small rise in HR: CO not maintained well
Respiratory	Rapid shallow breathing, Depress respiration, Reverses bronchospasm
Cerebral	↑ CBF and ICP, ↓ Cerebral metabolic oxygen requirements
Neuromuscular	Adequate muscle relaxation for intubation of children
Renal	Slight ↓ Renal blood flow Associated with impaired renal tubule function
Hepatic	↓ Portal vein blood flow

Sevoflurane

Biotransformation & toxicity

- Degraded by CO2 absorbent (barium hydroxide lime, soda lime) (alkaline pH), producing nephrotoxic end products **(compound A)**

Desflurane

- Halogenated Ether.
- High SVP which requires special vaporizer.
- Low solubility → *rapid onset and offset.*

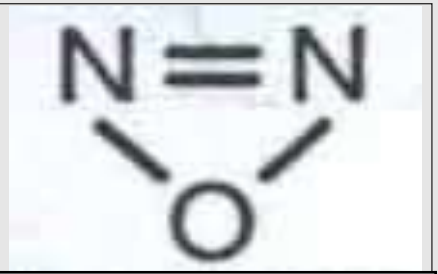
Physical properties	
MAC	6 %
Vaporiser concentration range	0-18%

Physiological effects	
CNS	↑ CBF, ICP:, lowered by hyperventilation ↓ Cerebral metabolic rate of oxygen
CVS	↓ Systemic vascular resistance: ↓ BP, CO: unchanged or slightly depressed (inc. in HR). Rapid increases in concentration lead to transient elevation in HR, BP, catecholamine levels
Respiratory	↓ Tidal volume:, ↑ respiratory rate: ↓ Alveolar ventilation: ↑ resting PaCO2, Depress the ventilatory response to ↑PaCO2 Pungency and airway irritation

Desflurane

- Degraded by desiccated CO2 absorbent into **carbon monoxide**

Nitrous Oxide



Physical properties	
MAC	105 %

- The only inorganic anesthetic gas in clinical use.
- Inert nature with minimal metabolism.
- Colorless, odorless, tasteless. Week Anesthetic good analgesic agent.

Physiological effects	
CNS	↑ CBF, cerebral blood volume, ICP, ↑ Cerebral oxygen consumption
CVS	Depress myocardial contractility but Arterial BP, CO, HR: unchanged or slightly↑ due to stimulation of catecholamines Constriction of pulmonary vascular smooth muscle → increase pulmonary vascular resistance Peripheral vascular resistance: not altered
Respiratory	↑ Respiratory rate and↓Tidal volume: minimal change in minute ventilation and resting arterial CO2, ↓ Hypoxic drive

Neuromuscular	Not provide significant muscle relaxation
Renal	↓ Renal blood flow: ↓ GFR and U/O
Hepatic	↓ Total hepatic blood flow
GIT	Increase nausea and vomiting

Nitrous Oxide

- Does not trigger malignant hyperthermia
- Inhibits vitamin B-12 metabolism
- Diffusion into closed spaces

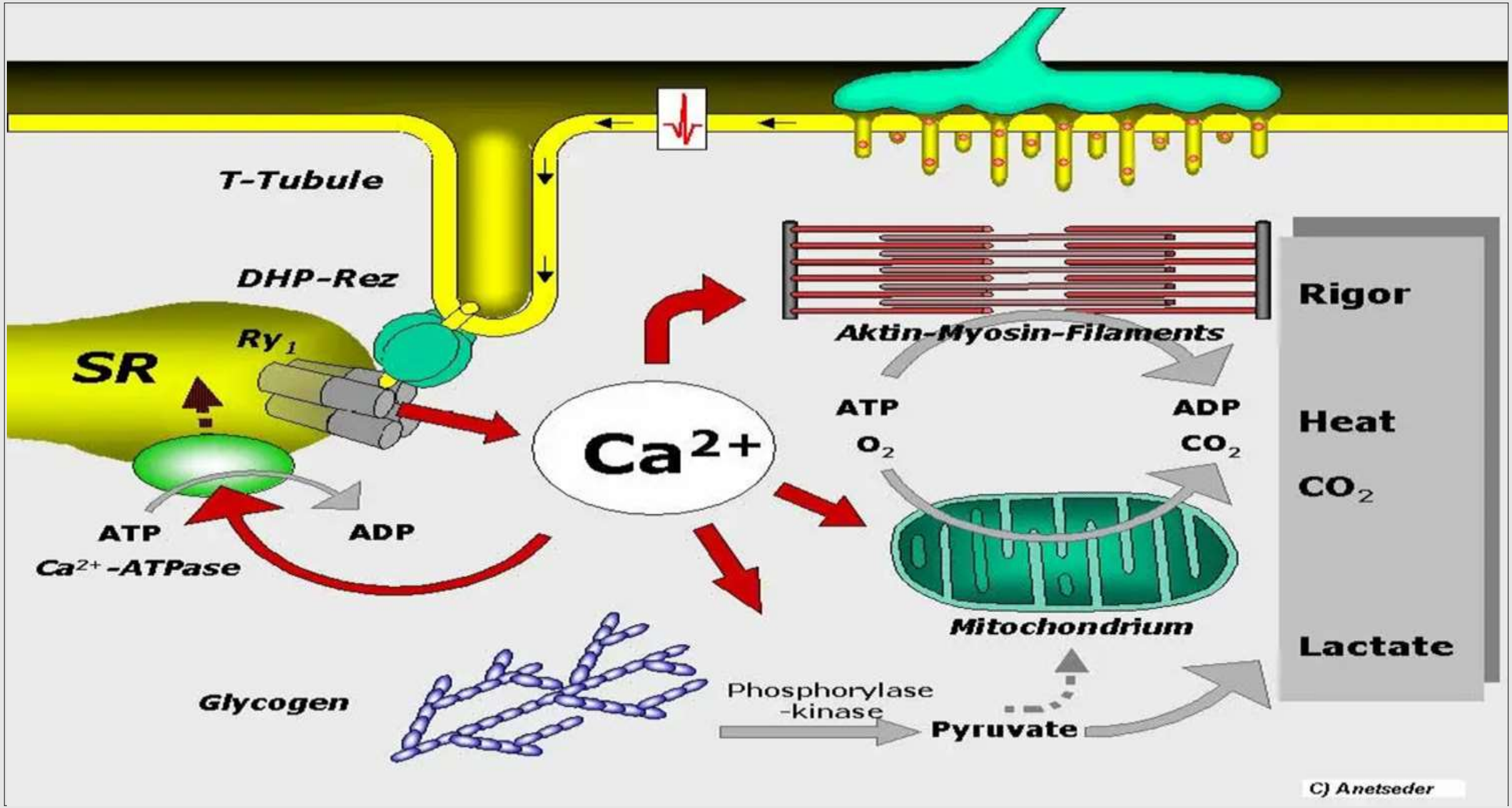
Xenon

- Nonexplosive, non-pungent, odorless and chemically inert
- No metabolism and low toxicity
- High cost
- MAC 71%
- It has some analgesic effect.
- Reduces anesthesia-emergent nausea and vomiting
- Very close to the ‘ideal agent’
- Minimal hemodynamic effects.
- Seems not to trigger malignant hyperthermia.

Malignant Hyperthermia

- **Genetic hypermetabolic disease (AD),** commonly appear with exposure to inhaled general anesthetics (except for N2O) or succinylcholine (triggering agents).
  - Gene for the ryanodine (Ryr1) receptor located on chromosome 19.
  - 1:15000 paediatrics to 1:40000 in adults
  - Induction, intraoperatively, or postoperatively
  - 50% occur on second exposure
  - Adult: Young males

- **Pathophysiology**: Uncontrolled sudden release of calcium from the sarcoplasmic reticulum skeletal muscles → increase in intracellular calcium → removes the inhibition of troponin → sustained muscle contraction.
- Markedly increase ATP activity → uncontrolled hypermetabolic state → increased oxygen consumption (hypoxia) and CO2 production (hypercapnia), severe lactic acidosis and hyperthermia.


T-Tubule
DHP-Rez
SR
Ry 1
Ca2+
ATP
Ca2+ -ATPase
ADP
Aktin-Myosin-Filaments
ATP
O2
ADP
CO2
Mitochondrium
Rigor
Heat
CO2
Lactate
Glycogen
Phosphorylase
-kinase
Pyruvate
C) Anetseder

Malignant Hyperthermia

Markedly increased metabolism
- Increased carbon dioxide production
- Increased oxygen consumption
- Reduced mixed venous oxygen tension
- Metabolic acidosis
- Cyanosis
- Mottling

Increased sympathetic activity
- Tachycardia
- Hypertension
- Arrhythmias

Muscle damage
- Masseter spasm
- Generalized rigidity
- Increased serum creatine kinase
- Hyperkalemia
- Hypernatremia

Hyperphosphatemia

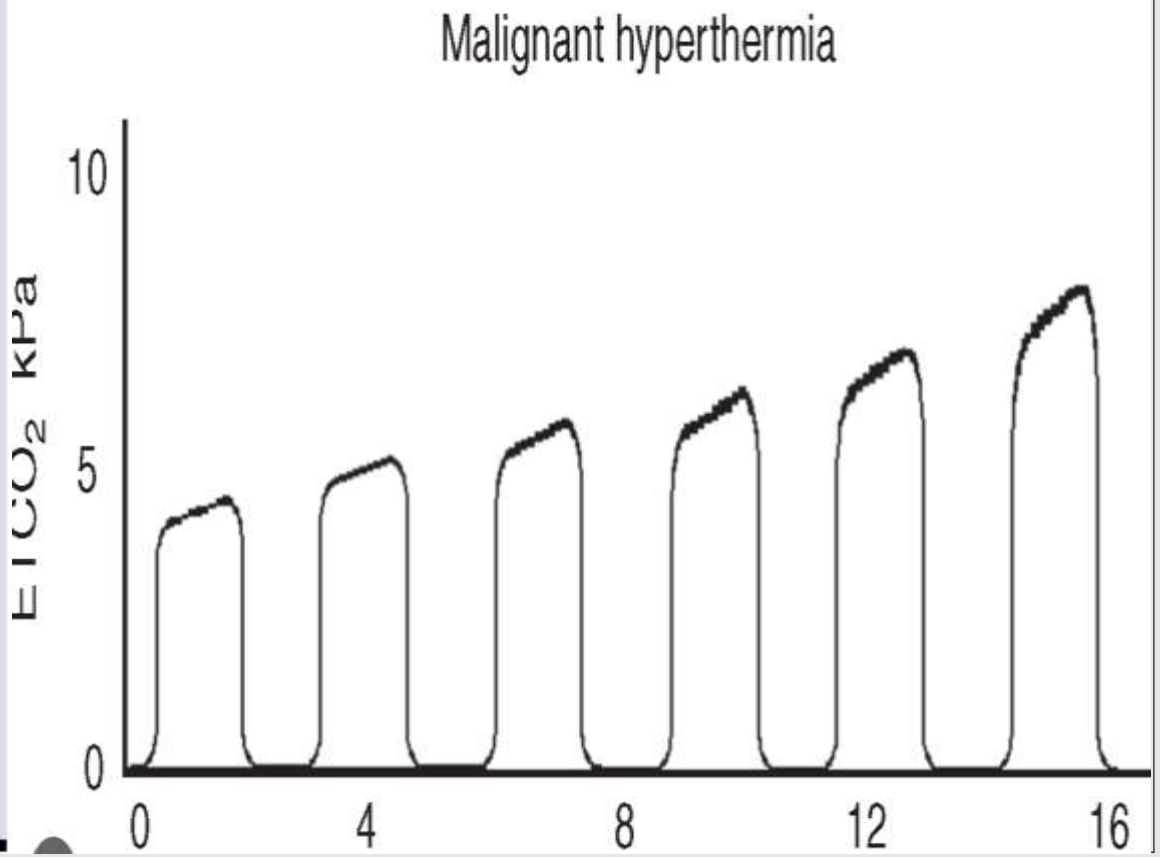
Myoglobinemia

Myoglobinuria

Hyperthermia

Fever

Sweating



Malignant Hyperthermia treatment and diagnosis

1. Discontinue volatile anesthetic and succinylcholine. Notify the surgeon. Call for help.
2. Mix dantrolene sodium with sterile distilled water, and administer 2.5 mg/kg intravenously as soon as possible.
3. Administer bicarbonate for metabolic acidosis.
4. Institute cooling measures (lavage, cooling blanket, cold intravenous solutions).
5. Treat severe hyperkalemia with dextrose, 25–50 g intravenously, and regular insulin, 10–20 units intravenously (adult dose).
6. Administer antiarrhythmic agents if needed despite correction of hyperkalemia and acidosis.
7. Monitor end-tidal CO_2 tension, electrolytes, blood gases, creatine kinase, serum myoglobin, core temperature, urinary output and color, and coagulation status.

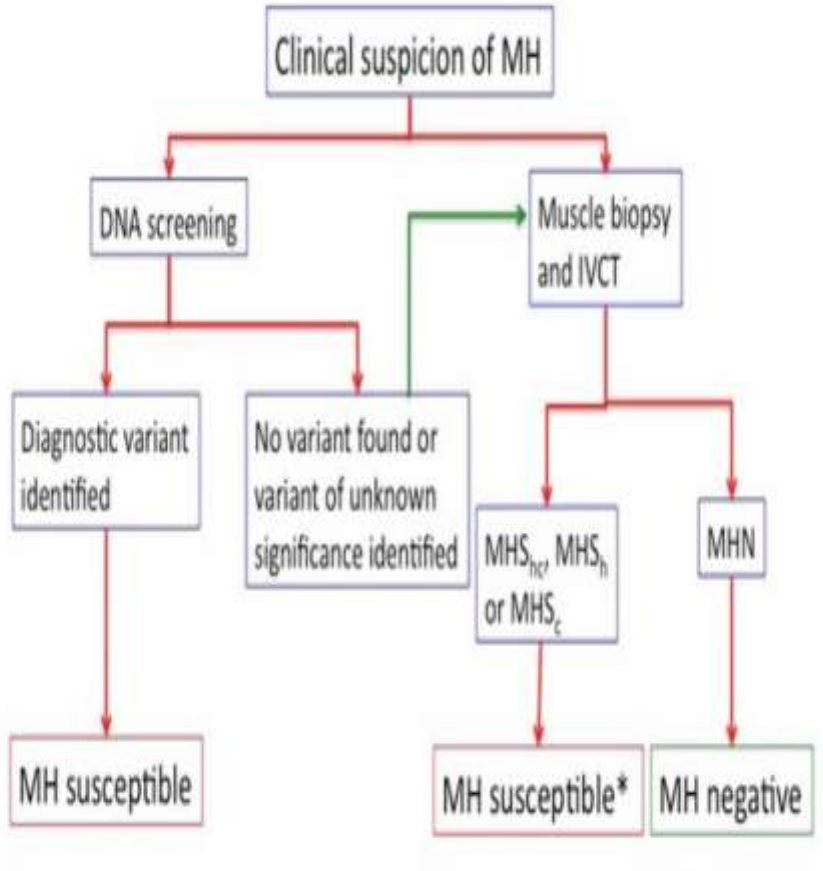


TABLE 8–6 Clinical pharmacology of inhalational anesthetics.

	Nitrous Oxide	Halothane	Isoflurane	Desflurane	Sevoflurane
Cardiovascular					
Blood pressure	N/C[1]	↓↓	↓↓	↓↓	↓
Heart rate	N/C	↓	↑	N/C or ↑	N/C
Systemic vascular resistance	N/C	N/C	↓↓	↓↓	↓
Cardiac output[2]	N/C	↓	N/C	N/C or ↓	↓
Respiratory					
Tidal volume	↓	↓↓	↓↓	↓	↓
Respiratory rate	↑	↑↑	↑	↑	↑
$Paco_2$					
Resting	N/C	↑	↑	↑↑	↑
Challenge	↑	↑	↑	↑↑	↑
Cerebral					
Blood flow	↑	↑↑	↑	↑	↑
Intracranial pressure	↑	↑↑	↑	↑	↑
Cerebral metabolic rate	↑	↓	↓↓	↓↓	↓↓
Seizures	↓	↓	↓	↓	↓
Neuromuscular					
Nondepolarizing blockade[3]	↑	↑↑	↑↑↑	↑↑↑	↑↑
Renal					
Renal blood flow	↓↓	↓↓	↓↓	↓	↓
Glomerular filtration rate	↓↓	↓↓	↓↓	↓	↓
Urinary output	↓↓	↓↓	↓↓	↓	↓
Hepatic					
Blood flow	↓	↓↓	↓	↓	↓
Metabolism[4]	0.004%	15% to 20%	0.2%	<0.1%	5%

[1]N/C, no change.

[2]Controlled ventilation.

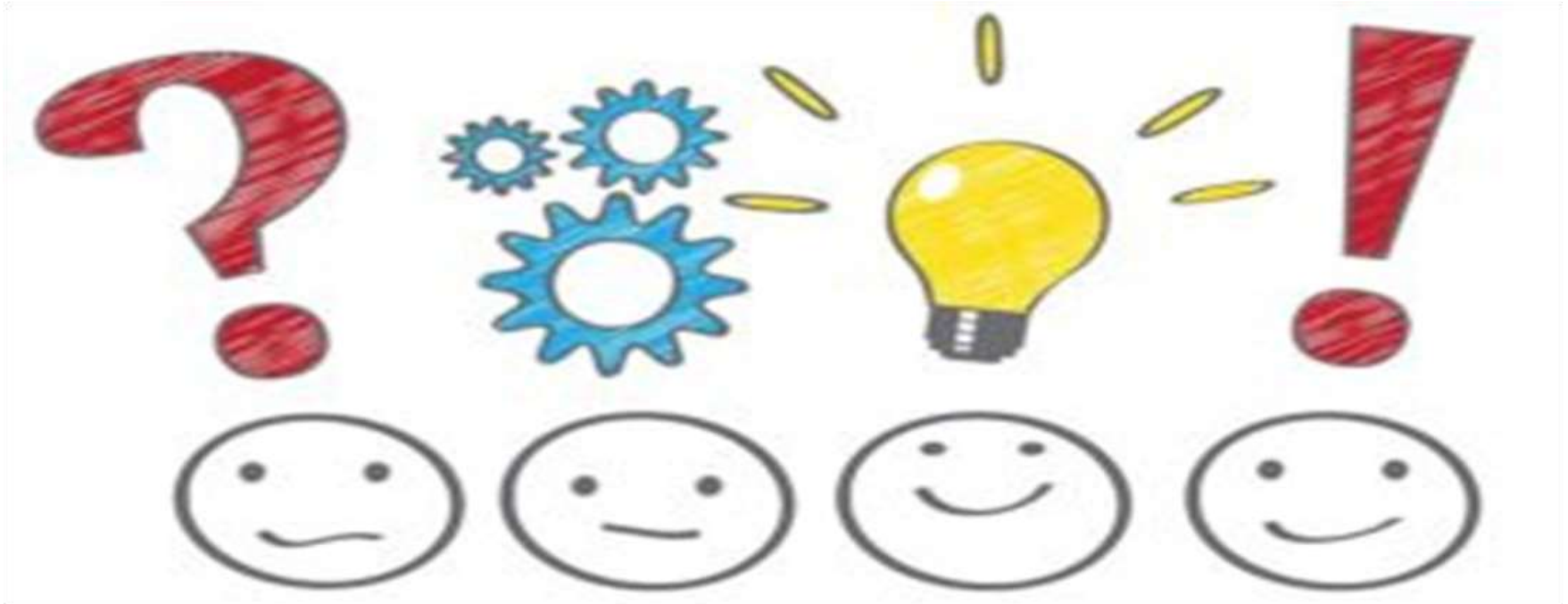
[3]Depolarizing blockage is probably also prolonged by these agents, but this is usually not clinically significant.

Figure 29.5 Ranking of clinical properties of volatile agents. D = desflurane, H = halothane, I = isoflurane, S = sevoflurane

	Worst	Worse	Better	Best
Induction	D	I	H	S
Cardiovascular stability	H	I	D	S
Respiratory irritation	D	I		H & S
Ease of titration	H	I	S	D
Emergence	H	I	S	D
Metabolism/toxicity	H	S	I	D

Figure 29.6 Grading of clinical properties of volatile agents. ○○○○ = least effect, ●●●● = maximum effect

	Halothane	Isoflurane	Desflurane	Sevoflurane
Pungency	●○○○	●●●○	●●○○	○○○○
Respiratory irritation	○○○○	●●○○	●●●○	○○○○
Respiratory depression	●●○○	●●●○	●●●●	●●○○
Cardiovascular depression	●●●○	●●○○	●○○○	●○○○
Coronary vasodilatation	●○○○	●●○○	●○○○	●●○○
Muscle relaxation	●●○○	●●●○	●●●○	●●●○
Intracranial pressure elevation	●●●●	●●○○	●●●○	●●○○



QUESTIONS !!!