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Changes in central venous saturation after major surgery, and association with outcome

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Critical Care 2005, **9**:R694-R699 (DOI 10.1186/cc3888)This article is online at: <http://ccforum.com/content/9/6/R694>© 2005 Pearse *et al.*; licensee BioMed Central Ltd.This is an open access article distributed under the terms of the Creative Commons Attribution License (<http://creativecommons.org/licenses/by/2.0>), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.**Abstract**

Introduction Despite recent interest in measurement of central venous oxygen saturation (ScvO₂), there are no published data describing the pattern of ScvO₂ changes after major general surgery or any relationship with outcome.

Methods ScvO₂ and other biochemical, physiological and demographic data were prospectively measured for 8 hours after major surgery. Complications and deaths occurring within 28 days of enrolment were included in the data analysis. Independent predictors of complications were identified with the use of logistic regression analysis. Optimum cutoffs for ScvO₂ were identified by receiver operator characteristic analysis.

Results Data from 118 patients was analysed; 123 morbidity episodes occurred in 64 these patients. There were 12 deaths (10.2%). The mean ± SD age was 66.8 ± 11.4 years. Twenty patients (17%) underwent emergency surgery and 77 patients (66%) were male. The mean ± SD P-POSSUM (Portsmouth Physiologic and Operative Severity Score for the enUmeration of Mortality and morbidity) score was 38.6 ± 7.7, with a

predicted mortality of 16.7 ± 17.6%. After multivariate analysis, the lowest cardiac index value (odds ratio (OR) 0.58 (95% confidence intervals 0.37 to 0.9); *p* = 0.018), lowest ScvO₂ value (OR 0.94 (0.89 to 0.98); *p* = 0.007) and P-POSSUM score (OR 1.09 (1.02 to 1.15); *p* = 0.008) were independently associated with post-operative complications. The optimal ScvO₂ cutoff value for morbidity prediction was 64.4%. In the first hour after surgery, significant reductions in ScvO₂ were observed, but there were no significant changes in CI or oxygen delivery index during the same period.

Conclusion Significant fluctuations in ScvO₂ occur in the immediate post-operative period. These fluctuations are not always associated with changes in oxygen delivery, suggesting that oxygen consumption is also an important determinant of ScvO₂. Reductions in ScvO₂ are independently associated with post-operative complications.

Introduction

The successful use of central venous oxygen saturation (ScvO₂) as a haemodynamic goal in the management of early sepsis has led to interest in the use of this parameter in surgical patients [1]. ScvO₂ measurement requires placement of a central venous catheter so that the tip lies in the superior vena cava. Readings may be taken intermittently by blood sampling and co-oximetry, or continuously with a spectrophotometric catheter. Experimental studies have shown that changes in

ScvO₂ closely reflect circulatory disturbances during periods of hypoxia, haemorrhage and subsequent resuscitation [2,3]. Fluctuations correlate well with those of mixed venous saturation (SvO₂), although absolute values differ [2,3]. Observational studies have described changes in ScvO₂ in various groups [4]. In particular, the prognostic significance of ScvO₂ reductions to below 65% has been demonstrated in trauma

Table 1**Demographic and biochemical data for patients with and without post-operative morbidity**

Data class	Complications (<i>n</i> = 64)	No complications (<i>n</i> = 53)	<i>p</i>
Demographic			
Age (years)	67.0 ± 12.3	66.7 ± 10.4	0.89
Blood loss (ml)	1,200 (520–2,000)	1,000 (725–2,350)	0.88
GDT	27/64 (42%)	35/53 (66%)	0.02*
APACHE II score	9.9 ± 4.3	9.0 ± 3.8	0.28
P-POSSUM score	40.1 ± 8.1	36.8 ± 6.8	0.02*
ASA score	3 (2–3)	3 (2–3)	0.61
Biochemical			
Baseline base excess (mmol l ⁻¹)	-2.62 ± 3.03	-2.40 ± 3.31	0.71
Lowest base excess (mmol l ⁻¹)	-3.67 ± 3.04	-4.30 ± 3.17	0.29
Base excess, 8-hour mean (mmol l ⁻¹)	-2.73 ± 3.83	-2.31 ± 3.15	0.44
Baseline lactate (mmol l ⁻¹)	1.49 ± 0.81	1.38 ± 0.74	0.43
Highest lactate (mmol l ⁻¹)	1.93 ± 1.30	1.80 ± 0.88	0.55
Lactate, 8-hour mean (mmol l ⁻¹)	1.29 ± 0.81	1.23 ± 0.55	0.65

*Statistically significant difference. Data are presented as means ± SD, medians (interquartile range) or absolute values (%). APACHE, Acute Physiology and Chronic Health Evaluation; GDT, patients receiving goal-directed therapy; P-POSSUM, Portsmouth Physiologic and Operative Severity Score for the enUmeration of Mortality and morbidity

[5], severe sepsis [6], myocardial infarction [7] and cardiac failure [8]. However, the only interventional trial of ScvO₂ conducted so far used a goal of 70% [1].

Although the association between cardiac index (CI), oxygen delivery index (DO₂I) and related parameters and outcome after major surgery has been well described [9–14], only limited data are available describing ScvO₂ values in the peri-operative period [15]. The physiology of ScvO₂ disturbances is complex. The value of ScvO₂ is determined by changes in oxygen delivery and consumption, both of which are subject to considerable variation during the peri-operative period [4]. It is not appropriate to assume that either the normal value or fluctuations in ScvO₂ will be similar to those of other patient groups. If ScvO₂ is to be used in the haemodynamic assessment of surgical patients, more detailed information is required describing fluctuations during the peri-operative period. The aim of this study was to describe changes in ScvO₂ after major general surgery and their relationship to outcome.

Methods

Patients

ScvO₂ data were collected from adult patients enrolled in the randomised study of post-operative goal-directed therapy (GDT) [16]. All patients were deemed to be at high risk of post-operative complications and were admitted to the intensive care unit (ICU) immediately after major surgery. This study was approved by the Local Research Ethics Committee of St George's Healthcare National Health Service Trust.

Assessment

All patients had arterial and central venous catheters placed before the commencement of surgery. The central venous catheter was positioned with the tip within the superior vena cava immediately above the right atrium. This position was verified by chest radiograph and adjusted if necessary. The following parameters were monitored continuously from arrival in the ICU immediately after surgery and for the next 8 hours: electrocardiograph, pulse oximetry, invasive arterial pressure, central venous pressure and cardiac output. Arterial and central venous blood gas analyses were performed by intermittent blood sampling and co-oximetry (ABL 700; Radiometer, Copenhagen, Denmark) at baseline and hourly during the 8 hours after surgery. This equipment was calibrated each hour, and routine quality control checks were performed. Cardiac output was measured by lithium indicator dilution and pulse power analysis (LiDCO plus system; LiDCO Ltd., Cambridge, UK). P-POSSUM (Portsmouth Physiologic and Operative Severity Score for the enUmeration of Mortality and morbidity) and APACHE II (Acute Physiology and Chronic Health Evaluation II) scores were calculated at admission to the ICU [17,18]. Complications and deaths occurring within 28 days of enrolment were included in the data analysis. Complications were prospectively defined, diagnosed by clinical staff and verified by a member of the research team. This process involved daily inspection of notes, radiological investigations, laboratory data and clinical assessment.

Table 2**Haemodynamic data for patients with and without post-operative morbidity**

Data class	Complications (<i>n</i> = 64)	No complications (<i>n</i> = 53)	<i>p</i>
Haemodynamic			
Baseline heart rate (beats min ⁻¹)	82.1 ± 21.4	81.5 ± 15.5	0.87
Highest heart rate (beats min ⁻¹)	100.3 ± 19.9	106.6 ± 22.4	0.11
Heart rate, 8-hour mean (beats min ⁻¹)	86.0 ± 16.3	90.3 ± 16.0	0.15
Baseline MAP (mmHg)	93.9 ± 19.4	99.6 ± 20.2	0.12
Lowest MAP (mmHg)	74.5 ± 14.7	76.3 ± 12.8	0.48
MAP, 8 hour mean (mmHg)	90.8 ± 15.3	92.5 ± 12.9	0.52
Baseline CI (l min ⁻¹ m ⁻²)	3.59 ± 1.39	3.87 ± 1.43	0.30
Lowest CI (l min ⁻¹ m ⁻²)	2.74 ± 0.79	3.25 ± 1.32	0.02*
CI, 8-hour mean (l min ⁻¹ m ⁻²)	3.93 ± 1.07	4.20 ± 1.55	0.30
Baseline DO ₂ I (ml min ⁻¹ m ⁻²)	494 ± 191	541 ± 229	0.26
Lowest DO ₂ I (ml min ⁻¹ m ⁻²)	364 ± 158	445 ± 218	0.02*
DO ₂ I, 8-hour mean (ml min ⁻¹ m ⁻²)	517 ± 206	581 ± 255	0.13
Baseline stroke volume (ml)	84 ± 30	88 ± 33	0.44
Lowest stroke volume (ml)	62 ± 25	70 ± 30	0.12
Stroke volume, 8-hour mean (ml)	70 ± 31	86 ± 32	0.29
ScvO₂			
Baseline (%)	76.2 ± 9.9	78.7 ± 6.2	0.11
Lowest (%)	63.4 ± 10.4	67.1 ± 7.7	0.03*
8-hour mean (%)	73.0 ± 6.6	75.0 ± 5.6	0.09

*Statistically significant difference. Data are presented as means ± SD. CI, cardiac index; DO₂I, oxygen delivery index; MAP, mean arterial pressure; ScvO₂, central venous saturation.

Clinical management

Protocols for cardiovascular management during the immediate post-operative period are provided in detail elsewhere [16]. Fluid challenges were guided by central venous pressure in 56 patients and by stroke volume in 61 patients. The latter group also received dopexamine if they did not achieve a DO₂I of 600 ml min⁻¹ m⁻² with fluid alone (GDT group). Once the 8-hour study period was complete, all patients received standard care for the remainder of their ICU and hospital stay. ScvO₂ data were not used to guide clinical management at any stage.

Statistical analysis

Data are presented as means ± SD where normally distributed, as medians (interquartile range) where not normally distributed or, for categorical variables, as a percentage of the group from which they were derived. Normality was tested with the Kolmogorov–Smirnov test. Categorical data were tested with Fisher's exact test. Continuous data were tested with the *t* test where normally distributed and the Mann–Whitney *U* test where not normally distributed. Trends in physiological parameters over time in the two groups were compared

with repeated-measures analysis of variance with Tukey's correction for multiple comparisons.

Univariate analysis was performed to test association with complications and death. For data recorded hourly during the study period, the baseline values, lowest values and the mean over the 8-hour study period were tested. A multiple logistic regression model was used to identify independent risk factors for post-operative complications. A stepwise approach was used to enter new terms into the logistic regression model, where *p* < 0.05 was set as the limit for inclusion of new terms. Results of logistic regression are reported as adjusted odds ratios (ORs) with 95% confidence intervals. Receiver operator characteristic curves were constructed to identify optimal cutoff values for association with outcome. The optimum cutoff was defined as the value associated with the highest sum of sensitivity and specificity. Analysis was performed with GraphPad Prism version 4.0 for Windows (GraphPad Software, San Diego, CA, USA) and significance was set at *p* < 0.05.

Table 3**Demographic and outcome data for high-ScvO₂ and low-ScvO₂ groups**

Parameter	High ScvO ₂	Low ScvO ₂	<i>p</i>
Number in group	64	53	-
Age	66 ± 12	69 ± 11	0.40
P-POSSUM	37.8 ± 7.4	39.0 ± 7.5	0.39
APACHE II score	9.8 ± 4.3	9.0 ± 3.9	0.30
Length of hospital stay (days)	12 (9–15)	14 (9–25)	0.25
Complications (number of patients)	29 (45%)	35 (66%)	0.03*
Complications (episodes per patient)	0.8 ± 1.1	1.4 ± 1.4	0.04*
Mortality	7 (11%)	4 (7%)	0.54

*Statistically significant difference. Data are presented as means ± SD, medians (interquartile range) or absolute values (%). APACHE, Acute Physiology and Chronic Health Evaluation; P-POSSUM, Portsmouth Physiologic and Operative Severity Score for the enUmeration of Mortality and morbidity; ScvO₂, central venous saturation.

Results

Data was collected from 117 patients between November 2002 and August 2004. Five patients were excluded from the analysis because ScvO₂ data were collected with a spectrophotometric catheter. Sixty-four patients developed 123 complications in all. There were 12 deaths (10.2%). The mean ± SD age was 66.8 ± 11.4 years. Twenty patients (17%) underwent emergency surgery and 77 patients (66%) were male. The APACHE II score was 9.5 ± 4.1, with a predicted mortality of 10.3 ± 9.0%. The P-POSSUM score was 38.6 ± 7.7, with a predicted mortality of 16.7 ± 17.6%. Fifty-seven (49%) patients were extubated within 1 hour of surgery and a further 29 (25%) were extubated before the end of the 8-hour study period.

Associations with outcome

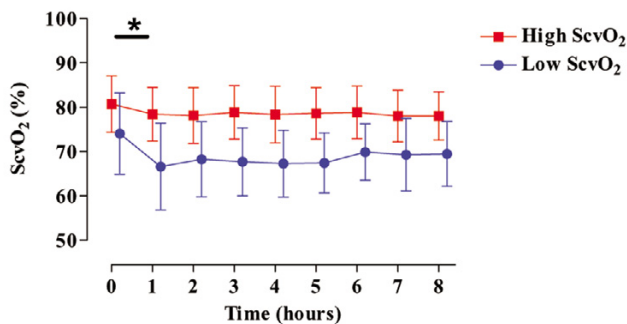
Commonly measured physiological, biochemical and demographic variables are presented in Tables 1 and 2. Although derangements in CI, DO₂I and ScvO₂ were frequently observed, other parameters remained within the normal range or were only slightly abnormal. Univariate analysis identified five variables associated with post-operative complications. These were the lowest ScvO₂ value, the lowest DO₂I value, the lowest CI value, the P-POSSUM score and the use of GDT. After multivariate analysis, the lowest CI value (OR 0.58 (95% confidence interval 0.37 to 0.9); *p* = 0.018), the lowest ScvO₂ value (OR 0.94 (0.89 to 0.98); *p* = 0.007) and P-POSSUM score (OR 1.09 (1.02 to 1.15); *p* = 0.008) were independently associated with post-operative complications. The lowest DO₂I value and use of GDT were not independent predictors of outcome. The optimal value of ScvO₂ to discriminate between patients who did or did not develop complications was 64.4% (sensitivity 67%, specificity 56%). Univariate analysis identified no associations with mortality.

Trends in ScvO₂

Patients were divided into two groups by using the optimal cutoff value for ScvO₂. Those in whom the lowest ScvO₂ value was 64.4% or below were defined as the low ScvO₂ group and those in whom the lowest value was above 64.4% were defined as the high ScvO₂ group (see Table 3). Trends in ScvO₂ and DO₂I are presented in Figures 1 and 2. During the first post-operative hour there was a significant decrease in ScvO₂ in both the high ScvO₂ group (79.8 ± 6.3% to 77.7 ± 5.8%; *p* = 0.016) and the low ScvO₂ group (74.6 ± 9.7% to 66.6 ± 10.3%; *p* < 0.0001). DO₂I and CI values did not change significantly during this time.

Discussion

The major finding of this study is the occurrence of considerable fluctuations in ScvO₂ after major general surgery that have prognostic significance. Multivariate analysis identified the lowest ScvO₂ value, lowest CI value and P-POSSUM score as independent predictors of complications. This observation supports the hypothesis that the association between reductions in ScvO₂ and outcome is similar to that observed previously for CI and DO₂I [9-13]. It is interesting to note that P-POSSUM score was an independent predictor of complications, but APACHE II score was not. This may be because P-POSSUM score was designed for use in surgical patients using data from the UK, whereas APACHE II was designed for use in mixed groups of critically ill patients using data from North America [17,18]. As might be expected, the use of GDT was associated with fewer post-operative complications. However, this association was not independent of other predictors of outcome. The observation of collinearity between CI, DO₂I and the use of GDT suggests that the level of DO₂I achieved by individual patients is more important than the approach to haemodynamic management.

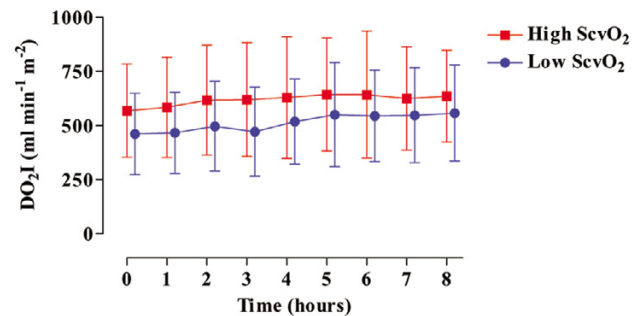
Figure 1

Central venous saturation (ScvO₂) in the 8 hours after major surgery. Results are means \pm SD. * $p < 0.0001$ for low ScvO₂ group; $p = 0.02$ for high ScvO₂ group. The difference between the high and low groups is significant overall and for each individual time point ($p < 0.0001$).

The optimal cutoff value of ScvO₂ for prediction of complications was 64.4%. This is very similar to the value (65%) identified in other patient groups [5-7]. Large fluctuations in ScvO₂ occur during the peri-operative period. Values of ScvO₂ decreased significantly during the first hour after surgery, while CI and DO₂I remained unchanged. A significant increase in oxygen consumption therefore occurred during this period despite the fact that fewer than half of the patients were extubated within 1 hour of surgery. This finding is consistent with previous findings in cardiac surgical patients [14], as well as earlier work by Shoemaker [13]. Post-operative oxygen consumption is determined by various factors including pain, emergence from anaesthesia, body temperature and shivering. Peri-operative disturbances of ScvO₂ cannot therefore be assumed to relate solely to DO₂I.

The 8-hour mean of ScvO₂ was 75.0% in patients who did not develop post-operative complications. This value was comparable to previous measurements in healthy conscious patients [19,20], but higher than those taken immediately before induction of anaesthesia [15] and in patients with good outcome after trauma, severe sepsis, cardiac failure or myocardial infarction [5-8]. It is notable that derangements in CI, DO₂I and ScvO₂ were observed in the absence of similar disturbances in other commonly measured biochemical and physiological variables. This was despite the high rates of morbidity and mortality in the study population. It is possible that disturbances in ScvO₂, CI and DO₂I might indicate the presence of occult tissue hypoperfusion before disturbances in other parameters.

The use of observational data from an interventional trial has both advantages and disadvantages. In this study, goals for arterial oxygen saturation, haemoglobin, heart rate, mean arterial pressure, serum lactate and urine output were the same in all patients. All clinical management and data collection were closely supervised by a member of the research team in

Figure 2

Oxygen delivery index (DO₂I) in the 8 hours after major surgery. Results are means \pm SD. The difference between the group with high central venous saturation (ScvO₂) and the low ScvO₂ group is significant overall ($p = 0.005$) but not for individual time points 7 and 8.

accordance with a carefully defined treatment protocol. The benefit of such rigorous study design must be offset against the fact that, in some patients, intravenous fluid administration was guided by central venous pressure, whereas in others fluid management was guided by stroke volume and supplemented with low-dose dopexamine. It is an inherent problem with studies of this type that the predictive nature of certain variables may relate both to the initial cardiovascular disturbance and subsequent attempts to correct it. The large number of statistical comparisons performed in the univariate analyses may seem speculative. This is not the case; comparisons made were of variables in which an association with outcome had previously been suggested [9-14,17,18,21]. We were therefore obliged to identify all such associations in the available data.

Conclusion

Reductions in ScvO₂ are common after major surgery and are associated with an increased rate of post-operative complications. Peri-operative changes in ScvO₂ relate to both oxygen consumption and delivery. Further evaluation of peri-operative trends in ScvO₂ should be performed before this variable is used as a haemodynamic goal in surgical patients.

Key messages

- The successful use of central venous saturation in the management of severe sepsis has led to interest in the use of this variable in surgical patients.
- This analysis suggests that central venous saturation may have prognostic significance following major surgery.
- Further evaluation of peri-operative trends in central venous saturation is required.

Competing interests

RP received a travel grant from LiDCO Ltd. to present data at an international meeting. JF has previously performed

consultancy work for LiDCO Ltd. DB currently performs consultancy work for LiDCO Ltd. and has previously performed consultancy work for Deltex Ltd. No other competing interests are declared.

Authors' contributions

RP, AR and DB were responsible for study design. RP, DD and JF were responsible for data collection. All authors were involved in data analysis and drafting the manuscript and approved the final version. All authors had full access to data and take responsibility for the integrity of the data and the accuracy of the analysis.

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