

Individualized Fluid Management

Subjects: Nursing

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Fluid management is a cornerstone in the treatment of burns and, thus, many different formulas were tested for their ability to match the fluid requirements for an adequate resuscitation.

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1. Introduction

In contrast to the goal-directed therapy, which uses a preset goal for every patient, the individualized approach considers co-morbidities and defines the goals in concordance to the individual organ function of every patient. As a consequence of increasing life expectancy, the average age as well as the incidence of co-morbidities has been rising significantly over the last few decades. Whereas occupational health and safety increased over the last years and occupation associated burns are decreasing likewise, the percentage of elderly and morbid patients rises continuously in developed countries^[1].

2. Cardiac Function and Fluid Responsiveness

In the course of burn resuscitation, cardiac function is a limiting factor for fluid administration. Thus, it is important to understand the pathophysiologic response to fluid challenges. In short, the myocardium is able to optimize its contractility in a certain range, i.e., within the steep part of the Frank–Starling curve. In this optimum range the myocardium is stretched by adequate preload without over-stretching in case of volume overload^[2]. Unfortunately, this optimum range is decreased by several cardiac diseases leading to poor fluid responsiveness. In these patients, low CO will not rise after fluid administration but rather deteriorate with increasing resuscitation volume. Thus, the preset goal of normalized CO is achievable for patients with normal cardiovascular responsiveness to fluid challenge. In contrast, further volume administration and increased preload have no benefit in non-responders. The assessment of cardiac function and fluid responsiveness is therefore a cornerstone of individualized resuscitation.

3. Parameters of Fluid Responsiveness

The transpulmonary thermodilution (TTD) technique as mentioned above can also be used to analyze the arterial pressure wave (PICCO®, PulseCO®, FloTrac®). The variation of the pulse pressure variation (PPV) and stroke volume variation (SVV) reliably predict the fluid responsiveness with a sensitivity of 80%^[3]. Furthermore, the analysis of the arterial pulse curve enables a continuous measurement and promptly demonstrates changes after increased fluid intake. Thus, the combination of TTD and pulse curve analysis (PICCO®, PulseCO®) not only displays hypovolemia via preload parameters (GEDV and ITBV) but also predicts fluid responsiveness^[4]. Unfortunately, arrhythmia, head of bed elevation^[5] as well as the settings of mechanical ventilation, low or changing tidal volume, spontaneous breathing and positive end-expiratory pressure (PEEP) especially, strongly influence SVV and PPV parameters ^[6]. Further parameters of fluid responsiveness are discussed in the following sections.

4. Point of Care Ultrasound—POCUS

The use of ultrasound as point of care diagnostic is now widely used. The most intriguing points are its rapid availability and non-invasive use. Additionally, the broad spectrum of applications ranges from identification of different causes of shock (hypovolemia versus pulmonary embolism etc.), examination of potential complications or combined injuries (pneumothorax, Focused Assessment with Sonography in Trauma/FAST), lung ultrasound, cardiac function, volumetric status and fluid responsiveness^[7]. Lung ultrasound is useful to estimate lung edema which is a stop sign for fluid administration similar to raised ELW values using the TTD technique.

As mentioned above, the diameter of the inferior vena cava (IVC) is an easily assessed but unreliable parameter for the actual volumetric status. However, the respiratory variation of the IVC—i.e., the dynamic changes in diameter during the

respiratory cycle—reliably reflects the volumetric status^[8]. The respiratory variation can be expressed as:

$$\text{IVC variability} = 100 \times \frac{\text{IVC}_{\text{maximum}} - \text{IVC}_{\text{minimum}}}{\text{IVC}_{\text{mean}}}$$

The cut-off point for the calculated IVC variability lies at 12% and, thus, measurements over 12% are predictive of fluid responsiveness^[8].

Though the variation is influenced by ventilator settings and respiration efforts in spontaneously breathing patients^[9], a recent meta-analysis by Zhang et al. showed a high specificity of the respiratory variation of the IVC of 87% and 85% in mechanical ventilation and spontaneous breathing, respectively. Additionally, sensitivity in mechanically ventilated patients was reliable with 81% but moderate in spontaneously breathing patients with 70%^[10]. Therefore, additional parameters are useful to assess fluid responsiveness, especially in spontaneously breathing patients.

5. Echocardiography

Focused cardiac ultrasound includes measurement of contractility of the left and right ventricle, stroke volume, valve dysfunction as well as respiratory changes (stroke volume variation) or changes after fluid challenges^{[11][12]}. Therefore, an initial assessment can be done and the responsiveness to fluid administration can be assessed in the course of resuscitation. Focused echocardiography can be done as transthoracic echocardiography (TTE) or transesophageal (TEE) the latter being more invasive and requiring sedation, yet being independent from mechanical ventilation or thoracic (burn) wounds.

Whereas overt hypovolemia can be determined quickly by visual assessment of the left ventricle (“kissing ventricles” as a typical sign), estimation of contractility and fluid responsiveness makes further measurements necessary. Herein, ejection fraction (EF) and stroke volume should be assessed as parameters for left ventricle contractility. The stroke volume (measured as velocity time index of the left ventricular outflow tract) is used to derive cardiac output^[13] and measurement of stroke volume variation during the respiratory cycle is equally to the SVV measured by TTD using the same cut-off values^[14]. Therefore, a SVV of 12–14% is highly predictive of a positive fluid response, whereas values below 10% reliably identify fluid non-responders^[15].

Recently, the contractility of the right ventricle has been focused on since it is crucial for fluid responsiveness. Therefore, the tricuspid annular plane systolic excursion (TAPSE) should be measured as parameter for right ventricular contractility and right ventricle dilatation and flattening of the septum as the “red flags” for fluid administration should not be missed^[16]. Echocardiography of the right ventricle also contributes to the interpretation of IVC measurements. Herein, a wide IVC diameter with low respiratory variation suggests a fluid non-responder. In combination with right ventricle dilatation, this constitutes a red flag for any further fluid administration.

6. Fluid Responsiveness and Fluid Challenge

Additionally, these parameters can be re-assessed after a fluid challenge. Therefore, mini-fluid challenges of 100 mL of colloids are sufficient to certify fluid responsiveness by optimizing cardiac output by at least 10%^[17]. Instead of fluid administration, the passive leg raise (PLR) maneuver also enables a fluid challenge of 250–300 mL by auto-transfusion. In contrast to intravenous fluid administration, the volume effect after PLR persists for 20–45 min and is, thus, reversible. When PLR test is conducted correctly (change patient's position from semirecumbent to supine with legs 45° elevated) and CO or SVV are measured before and 1–2 min after changing the patient's position, this test is easy to perform and highly reliable. A meta-analysis of Cherpanath and colleagues found a pooled sensitivity of 86% and specificity of 92% with a summary AUROC of 0.95^[18]. Contraindications for PLR maneuver are raised intracranial pressure, intra-abdominal hypertension and lower limb amputations, the last two conditions attenuating the effect of PLR maneuver and therefore leading to unreliable results.

In contrast to single measurements of SVV or cardiac output, the change after volume challenge—nevertheless, via fluid administration or PLR—is independent from ventilator settings, spontaneous breathing or arrhythmia^[18]. Thus, the dynamic analysis of fluid responsiveness using PLR/fluid challenge results in more robust measurements and are therefore useful in a variety of clinical settings.

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