Cardiac pharmacological preconditioning with volatile anesthetics: from bench to bedside?

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Departments of 1Anesthesiology, 2Physiology, and 3Pharmacology and Toxicology and 4Department of Medicine, Division of Cardiovascular Diseases, and 5Cardiovascular Research Center, Medical College of Wisconsin, Milwaukee 53226; 6Department of Biomedical Engineering, Marquette University, Milwaukee 53233; 7Clement J. Zablocki Department of Veterans Affairs Medical Center, Milwaukee, Wisconsin 53295; and 8Department of Anesthesiology and Intensive Care Medicine, University Hospital Münster, 48129 Münster, Germany

Riess, Matthias L., David F. Stowe and David C. Warltier. Cardiac pharmacological preconditioning with volatile anesthetics: from bench to bedside? Am J Physiol Heart Circ Physiol 286: H1603–H1607, 2004; 10.1152/ajpheart.00963.2003.—A steadily increasing number of investigations demonstrate that preconditioning with volatile anesthetics attenuates the deleterious effects of myocardial ischemia and reperfusion injury by an ischemic preconditioning-like mechanism. Thus volatile anesthetics may represent the best choice for anesthesia of patients at risk for myocardial ischemia. However, factors such as old age, coexisting conditions such as diabetes mellitus and the use of oral hypoglycemic drugs or cyclooxygenase inhibitors, timing and duration of myocardial ischemia, and possible constraints of a complicated preconditioning protocol may limit the benefits of this powerful tool under clinical conditions. The purpose of this minireview is to provide a brief overview of the results of basic and clinical research on cardioprotection by volatile anesthetics.

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ple, patients who experience prodromal symptoms of myocardial angina within 24 h before subsequent acute myocardial infarction demonstrate a more rapid recovery and improved survival (16). However, to protect a patient’s heart against injury by possible or planned ischemia and reperfusion, inducing preconditioning by pharmacological means seems more applicable. Volatile anesthetics have been successfully used in patients for decades and may offer a useful role in patients with coronary artery disease undergoing surgery.

**Anesthetic Preconditioning**

In a fashion similar to ischemic preconditioning, volatile anesthetics can trigger an acute cardioprotective memory effect that lasts beyond their elimination (5, 6, 23). This early preconditioning has been prevented by adenosine A1 receptor antagonists (46), G protein inhibitors (61), reactive oxygen species scavengers (25, 36, 39, 57), PKC inhibitors (6, 38, 62, 65), K<sub>ATP</sub> channel blockers (23, 41, 45, 46, 60, 69), and cyclooxygenase type 2 inhibitors (35). Although the exact signaling pathway is not yet fully understood, all of these observations suggest that volatile anesthetics precondition the myocardium by mechanisms similar to ischemic preconditioning but they have the distinct advantage of not requiring ischemia to produce this effect. Volatile anesthetics are lipophilic and can easily diffuse through cellular and subcellular membranes. They do not require ionic or covalent binding to specific receptors but can interact with lipophilic amino acids to cause conformational changes in membranes, channels, and enzymes (10). In this way, like other lipophilic drugs (28, 34), they can alter mitochondrial electron transport (26, 43, 45). This is thought to cause enhanced electron leakage and reactive oxygen species generation, which may act as a trigger for preconditioning (25, 36, 39, 57) and lead to PKC activation (38), K<sub>ATP</sub> channel opening (30, 72), and differential gene regulation (70). For more detailed reviews on mechanisms of anesthetic preconditioning, see Refs. 7, 47, 53, 55, 71, and 73. By conferring protection to the myocardium as well as to other tissues (18, 33) beyond the duration of the anesthetic exposure during anesthesia, anesthetic preconditioning may offer additional benefits during the vulnerable postoperative period.

**Preconditioning of the Aged Heart**

The majority of research into cardioprotective measurements involves models using younger animals. Interestingly, cardioprotective strategies would be most beneficial for the middle-aged and elderly. Tolerance to stress in older animals is generally lower than that in younger animals, and most cardiac complications in humans occur later in life. Therefore, preconditioning of the aged myocardium is an important issue that may differ considerably from preconditioning of myocardium in the younger so that cardioprotection may need to be tailored to the aged population (for a review, see Ref. 59). Some investigators have found that age does not influence the myocardial tolerance to ischemia or the protective effect of ischemic preconditioning (31), whereas other studies question the ability of aged myocardium to be susceptible to preconditioning at all (1). Schulman et al. (49), for example, reported that aged rat hearts could not be preconditioned by ischemic or pharmacological means and that middle-aged rat hearts had only a blunted response to preconditioning compared with young adult hearts. They suggested defects within the signaling cascade of preconditioning in the aged heart. Evidence from an isolated heart model points in the same direction for anesthetic preconditioning, suggesting that the benefits of anesthetic preconditioning may indeed be reduced with advanced age (52). In any case, the role of pharmacological and anesthetic preconditioning in aged hearts needs to be thoroughly investigated before any conclusion can be drawn as to its applicability in the clinical situation.

**Preconditioning and Diabetes Mellitus**

Acute and chronic hyperglycemia increases the risk for cardiac ischemic injury. Endogenous protective signaling pathways are impaired, and coronary blood flow to the ischemic myocardium is reduced during hyperglycemia. Despite the experimental evidence that hyperglycemia adversely alters cardiac signal transduction and impairs regulation of coronary hemodynamics, no clinical trial has been conducted so far to modify the perioperative cardiovascular risk in diabetic patients. Nevertheless, perioperative blood glucose control may prove beneficial (for a review, see Ref. 14).

Adequacy of control of blood glucose concentration will affect anesthetic preconditioning. High blood glucose concentrations have been shown to antagonize ischemic and anesthetic preconditioning in the presence and absence of diabetes in different animal models (9, 19, 22, 54). Even if adult-onset diabetes mellitus is successfully treated, in part or solely, by sulfonylurea oral hypoglycemic drugs such as glibenclamide, patients will most likely not benefit from any form of preconditioning. The target of sulfonylurea drugs is the K<sub>ATP</sub> channel in the pancreatic β-cell: closure of the K<sub>ATP</sub> channel causes insulin release. K<sub>ATP</sub> channels are also present in sarcolemmal and possibly in mitochondrial membranes of cardiac myocytes (13). Their activation has been implicated as both a trigger and effector of myocardial preconditioning, and both ischemic and anesthetic preconditioning are abolished by sulfonylurea drugs. Oral hypoglycemic agents should therefore be discontinued 24 h before elective surgery. Instead, insulin should be used to maintain normoglycemia. Insulin has the added benefit of activating cell survival pathways, including the phosphatidylinositol 3′-kinase/Akt-dependent pathway to decrease infarct size and apoptotic myocyte death (12).

**Timing and Duration of Ischemia**

To demonstrate the beneficial effects of anesthetic preconditioning and to study the signal transduction pathways involved, investigators have to select a specific duration of ischemia that varies among models and species. If the ischemia is too short, the damage is not serious enough to be attenuated by preconditioning. If the ischemia is too long, preconditioning is not powerful enough to improve the outcome. Kevin et al. (24) in a recent study in isolated hearts found an optimal effect of anesthetic preconditioning only for a limited ischemia duration of ∼25 min. They also showed that preconditioned hearts only tolerate ischemia ∼10 min longer than nonpreconditioned hearts to result in the same tissue damage. However, coronary perfusion was better maintained after preconditioning for up to 45 min ischemia suggesting better preservation of vascular than mechanical function. Thus it appears that only when the duration of ischemia falls within a certain window...
does the myocardium benefit from preconditioning. Varying
tolerance to ischemia among different species (50) may alter
the duration of this window and further complicate transfer-
ability of results from animal studies to the clinical situation.

Another issue is that the cardioprotective effects of anes-
thetic and other forms of pharmacological preconditioning last
only for a limited time after the preconditioning stimulus, i.e.,
a first window. Patients with coronary artery disease undergo-
ing noncardiac surgery, however, have the greatest severity of
perioperative myocardial ischemia at times over 24 h postop-
eratively (32). In this context, a second window of anesthetic
preconditioning after 24 h, as reported for ischemic precondi-
tioning, would certainly be beneficial in the clinical setting.
However, studies on whether a second window of anesthetic
preconditioning exists (similar to ischemic preconditioning)
have furnished inconsistent results (21, 56, 63).

Application
Cardioprotection by anesthetic preconditioning may have
important implications in the clinical setting. One is cardio-
protection against possible ischemia during the perioperative
period in patients with coronary artery disease undergoing non-
cardiac surgery. The other is protection against the myocardial
ischemia expected to occur during cardiac surgery or coronary
angioplasty.

The question at hand for the clinician is how anesthetic
preconditioning can be best achieved in the clinical setting. A
supraclinical concentration (four minimal alveolar concentra-
tions [MAC] sevoflurane) led to a better cardioprotection than
a lower concentration (2 MAC) as shown by postschismic
function and infarct size in an isolated heart model (42).
Transferring these results into clinical practice, however, is
limited by the marked cardiodepressant side effects of such a
high concentration, especially when treating patients who al-
ready have impaired cardiac function. Whether anesthetic pre-
conditioning is dose dependent in vivo and within the range of
clinically applicable concentrations has not yet been fully
elucidated (20).

At least for ischemic preconditioning, several cycles of
preconditioning have been shown to improve outcome com-
pared with only one cycle (48), suggesting greater accumula-
tion of critical mediators of preconditioning with each cycle.
It is unclear whether anesthetic preconditioning can be enhanced
by administering the volatile anesthetic in several cycles of
exposure interspersed with its washout. So far, data from an
isolated heart model suggest that this may be the case (44), but
no in vivo study has been conducted yet to support this
evidence. If repeated washout of the anesthetic proves critical
to improving anesthetic preconditioning at clinically relevant
centers, allowing enough time for sufficient washout to
occur in vivo may be severely constrained by practical consid-
erations during anesthesia and surgery.

Clinical Studies
Because of obvious limitations it has been difficult in the
past to provide sufficient evidence for anesthetic precondi-
tioning in clinical studies. A few clinical studies with a small
number of patients have been conducted, with somewhat lim-
ited success. The beneficial effects of volatile anesthetics in
elderly high-risk patients undergoing elective coronary artery
bypass grafting have so far been confined to surrogate markers.
In a study by Belhomme et al. (3) on patients age 70 ± 9 yr
undergoing elective coronary artery bypass grafting, anesthetic
preconditioning was elicited after the onset of cardiopulmonary
bypass by a 5-min exposure to 2.5 MAC isoflurane, followed
by a 10-min washout before aortic cross-clamping and car-
diopulmonary arrest. The authors found a smaller release of tropo-
in I and creatine kinase-MB. Julier et al. (17) preconditioned
with 2 MAC sevoflurane during the first 10 min of cardiopul-
monary bypass and found a decreased release of brain natri-
uretic peptide postoperatively compared with control patients.
Perioperative ST segment changes, frequency of dysrhythmias,
and creatine kinase-MB or cardiac troponin release were not
different between groups. Van Der Linden et al. (66) investi-
gated the effects of several anesthetics on recovery of myocar-
dial function in coronary surgery patients older than 70 yr with
three-vessel disease and an ejection fraction <50%. The vol-
atile anesthetics sevoflurane and desflurane preserved left ven-
tricular function after surgery with less evidence of myocardial
damage postoperatively (66). Although these results suggest a
beneficial effect of cardioprotection and preconditioning by
volatile anesthetics in elderly patients with coronary artery
disease, no clinical investigation to date has shown decreased
long-term morbidity and mortality by anesthetic precondi-
tioning.

In conclusion, a steadily increasing number of nonclinical
investigations demonstrate that preconditioning with volatile
anesthetics can attenuate myocardial ischemia and reperfusion
injury. Protection by volatile anesthetics is likely afforded by
an ischemic preconditioning-like effect as they appear to re-
versibly alter mitochondrial function, a major factor in induc-
ing preconditioning. Volatile anesthetics are easily eliminated
from the body and cause no lasting deleterious effect. Thus
volatile anesthetics are likely a good choice for anesthesia in
patients at risk for myocardial ischemia. However, factors such
as old age, coexisting disease, the use of oral sulfonylurea
drugs or cyclooxygenase 2 inhibitors, timing and duration of
myocardial ischemia, and practical constraints of a possibly
complicated preconditioning protocol may limit the benefits of
these drugs under clinical conditions. Well-planned multi-
center clinical studies are needed to transfer the results of basic
research into clinical practice.

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Invited Review

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