Microdialytical monitoring of uric and ascorbic acids in the brains of patients after severe brain injury and during neurovascular surgery

H Langemann, T Feuerstein, A Mendelowitsch, O Grätzl

Abstract

Objectives—Microdialysis has been extensively used to monitor brain metabolism in the extracellular fluid of patients with severe head injury, to detect the onset of secondary ischaemic damage. The aim was to investigate whether concentrations of uric and ascorbic acids were altered in such patients. Both these compounds play a part in free radical metabolism, which is accelerated after ischaemia and brain injury.

Methods—Patients with aneurysm or bypass operations were monitored intraoperatively to assess concentrations in minimally disturbed tissue. Afterwards, 13 patients with severe head trauma were monitored for up to 13 days in the intensive care unit.

Results—Intraoperatively, concentrations of both ascorbic and uric acids were significantly higher in the bypass group than in patients with aneurysm, which might be attributed to chronic ischaemic conditions caused by the unilateral occlusion of the carotid artery. In the patients with trauma, mean values of uric acid, varying between 6 μM and 180 μM, did not correlate with type of injury (contusion or diffuse) or duration of monitoring time. Patients who died had significantly higher concentrations of uric acid than those with a good outcome. Ascorbic acid could be detected only intermittently, probably due to technical problems. Concentrations of these two compounds could not be correlated with clinical findings during the course of monitoring.

Conclusions—Although uric and ascorbic acids are influenced by ischaemic conditions—for example, in bypass patients, neither compound is suitable for monitoring for free radical activity after severe head injury. Patients with a bad outcome tended to have higher concentrations of uric acid.

INTRAOPERATIVE PROCEDURES

Measurements were carried out during 11 aneurysm operations and six extra-intracranial bypass operations. Temporary clipping and burst suppression with barbiturates were performed in all patients. The bypass patients
received heparin locally at the site of the bypass. The method used has been described previously.11 Immediately after the craniotomy a 1 cm cut was made in the dura and the probe (4 mm membrane, 0.5 mm diameter), which had been previously sterilised at 60 °C with ethylene dioxide, was inserted into the cortex (frontally for the aneurysm operations; temporally for the bypass operations, 1–1.5 cm from the bypass site). Probes were perfused with 0.9% saline at a flow rate of 2 µl/min. In two patients with very short operation times a flow rate of 4 µl/min was used. Samples were collected every 20 or 30 minutes until the dura was closed (total monitoring time 100–375 minutes for aneurysm operations, 110–225 minutes for bypass operations).

INTENSIVE CARE
Thirteen patients with severe head trauma, who were all comatose with a Glasgow coma score (GCS)<8 before and during monitoring, were monitored in the intensive care unit (ICU). The probe was inserted into normal tissue, as defined by CT; this was usually frontally on the right side, using a four lumen transcranial screw.12 CMA 70 microdialysis probes (sterile, 1 cm membrane) were perfused with sterile perfusion fluid (artificial CSF from CMA/Microdialysis) at a flow rate of 0.3 µl/min. Samples were collected hourly. The clinical and microdialytical data of the patients are given in table 1.

ANALYSIS
Samples collected during operations were immediately cooled and kept at −20°C or cooler until analyzed. Samples collected in the intensive care unit were analyzed in a CMA/600 analyzer (a self calibrating autoanalyzer using enzyme fluorimetric assays) for glucose, lactate, and glutamate (2.5 µl) before cooling. Samples were later analyzed (5 or 10 µl) for UA and Asc using reverse phase high performance liquid chromatography (HPLC) with electrochemical detection at a gold electrode set at 0.65 mV.13 Glucose and lactate were also analysed using enzymatic methods.11 Basal concentrations during operations were calculated as the mean of all samples excluding the first ones, and those collected during surgical retraction. Statistical analysis was carried out using the program StatView 5.0 (SAS Institute, North Carolina, USA).

RECOVERY
The microdialysis probes used had a cut off of 20 000 Da. The molecular weights of Asc and UA are 176 and 168 respectively. In vitro recoveries at 2µl/min with a membrane length of 4 mm were about 12% for Asc and 21% for UA. Using a 10 mm membrane with a flow rate of 0.3 µl/min, in vitro recovery for UA was about 85%, for Asc 60%.

Results
INTRAOPERATIVE
Uric acid and Asc could be detected in dialysates from all patients during the cerebrovascular procedures. Basal concentrations in the patients with aneurysm (minimally disturbed tissue) were mean (SEM) 5.6 (0.6) µM for UA, and 7.7 (0.8) µM for Asc. Concentrations of both UA and Asc were significantly higher (Mann Whitney U test) in patients undergoing bypass operations (8.5 (0.9) µM for UA, 10.3 (0.7) µM for Asc (fig 1). Temporary clipping with local application of heparin had no effect on any microdialytically measured variable. In six of the patients retraction led to changes typical for ischaemic conditions in the region of the probe (increases in

<table>
<thead>
<tr>
<th>Patient No</th>
<th>Age, sex</th>
<th>Hours monitored</th>
<th>UA mean (SD)</th>
<th>Time after injury of probe insertion</th>
<th>CT finding</th>
<th>GOS</th>
<th>ICP/CPP mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>59</td>
<td>60, M</td>
<td>148</td>
<td>20.2 (7.4)</td>
<td>16 h</td>
<td>c</td>
<td>2</td>
<td>&lt;15/&gt;60</td>
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<tr>
<td>60</td>
<td>68, M</td>
<td>57</td>
<td>89.4 (20.8)</td>
<td>3 days</td>
<td>c</td>
<td>2</td>
<td>&lt;15/&gt;60</td>
</tr>
<tr>
<td>61</td>
<td>21, F</td>
<td>232</td>
<td>21.8 (8.0)</td>
<td>12 h</td>
<td>d</td>
<td>5</td>
<td>&lt;15/&gt;60</td>
</tr>
<tr>
<td>64</td>
<td>44, M</td>
<td>118</td>
<td>10.2 (1.5)</td>
<td>12 h</td>
<td>c</td>
<td>3</td>
<td>&lt;15/&gt;60</td>
</tr>
<tr>
<td>65</td>
<td>57, M</td>
<td>80</td>
<td>135.9 (81.2)</td>
<td>6 h</td>
<td>d</td>
<td>1</td>
<td>48/50</td>
</tr>
<tr>
<td>66</td>
<td>31, M</td>
<td>150</td>
<td>10.4 (10.0)</td>
<td>5 h</td>
<td>c</td>
<td>4</td>
<td>&lt;15/&gt;60</td>
</tr>
<tr>
<td>67</td>
<td>26, M</td>
<td>38</td>
<td>30.0 (12.4)</td>
<td>7 h</td>
<td>c</td>
<td>2</td>
<td>26/61</td>
</tr>
<tr>
<td>68</td>
<td>54, M</td>
<td>66</td>
<td>101.2 (57)</td>
<td>8 h</td>
<td>c</td>
<td>1</td>
<td>&lt;15/&gt;60</td>
</tr>
<tr>
<td>69</td>
<td>23, M</td>
<td>312</td>
<td>26.6 (12.1)</td>
<td>4 h</td>
<td>c</td>
<td>2</td>
<td>&lt;15/&gt;60</td>
</tr>
<tr>
<td>70</td>
<td>37, F</td>
<td>20</td>
<td>19.8 (33)</td>
<td>7 h</td>
<td>d</td>
<td>5</td>
<td>&lt;15/&gt;60</td>
</tr>
<tr>
<td>71</td>
<td>47, M</td>
<td>48</td>
<td>6.0 (2.3)</td>
<td>8 h</td>
<td>d</td>
<td>2</td>
<td>&lt;15/&gt;60</td>
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<tr>
<td>72</td>
<td>42, F</td>
<td>68</td>
<td>33.5 (14.4)</td>
<td>7 h</td>
<td>d</td>
<td>1</td>
<td>&lt;15/&gt;60</td>
</tr>
<tr>
<td>73</td>
<td>37, M</td>
<td>59</td>
<td>183.9 (30)</td>
<td>17 h</td>
<td>d</td>
<td>1</td>
<td>&lt;15/&gt;60</td>
</tr>
</tbody>
</table>

CT finding: c=contusion; d=diffuse injury.
GOS=Glasgow outcome scale. 1=dead; 2–3=poor; 4–5=good.

Figure 1 Mean (SEM) concentrations of uric acid (UA) and ascorbic acid (Asc) in cortical dialysates collected from patients undergoing cerebrovascular operations. Aneurysms, n=11; bypass operations, n=6; *p<0.05, Mann Whitney U test.
Asc, UA, and lactate and reductions in glucose and pH). Conditions normalised rapidly, sometimes even before the end of retraction.

CASE REPORTS

Three of the 13 patients are described in detail. Results for UA, Asc, glucose, lactate, and glutamate for the three patients are shown in figures 2, 3, and 4 and ICP together with cerebral perfusion pressure (CPP) for patient 65 in figure 4).

Patient 59

Patient 59 (male 60 years old, fig 2) fell down the stairs. At the scene of the accident the patient was unconscious with normal flexion of the limbs (GCS 6). Brain CT showed a left occipital fracture of the skull, an intracerebellar haemorrhage, a subarachnoid haemorrhage, and blood within the cisterna magna. The haemorrhage compressed the brain stem, so an occipital craniectomy was carried out and the haematoma was evacuated. Then the patient was transferred to the intensive care unit, where a multiparametric screw was inserted into undamaged tissue on the right side. During the period of monitoring the ICP never went above 13 and CPP was never pathologi-cal. All other clinical variables remained stable and within the normal range. Monitoring time was 7 days. Glucose, lactate, and glutamate all showed acceptable values. Ascorbic acid was measurable in less than half the samples, remaining under 25 µM. Uric acid was not high and showed a relatively stable course, the initial value of about 30 µM being reduced to about 18 µM at the end of monitoring. The outcome after 6 months was severely handicapped (Glasgow outcome scale (GOS) 3).

Patient 61

Patient 61 (female, 21 years old, fig 3) had a traffic accident, resulting in multiple fractures (craniofacial and of the lower limbs). Brain CT did not show any intracranial pathology. Initially the patient was unconscious with normal flexion of the limbs (GCS 6). The probe was inserted into undamaged tissue frontally on the right side. At the start of monitoring, ICP was normal. However during the first 36 hours there were several short periods with high ICP, during which ICP rose to over 100 mm Hg for 10–15 minutes. Afterwards, ICP was stable and in the normal range. The patient was in a coma for 12 days before she regained consciousness spontaneously. In this patient glucose, lactate, and glutamate were normal. At first Asc was not measurable, then there was a sudden unexplained episode of extremely high concentrations (over 1000 µM) from 100 to 140 hours, followed by several hours when it was again not measurable. During this time, UA was relatively stable at about 25 µM. At 140 hours, UA started to decrease to a final concentration of 10 µM and Asc started to increase. Shortly afterwards the patient became conscious. She recovered without any neuro-logical deficits (GOS 5).
INTENSIVE CARE

Uric acid could be measured in all patients with trauma. Concentrations mostly did not show very marked changes during the course of monitoring (for example, patient 59, fig 2 ).

Mean values during the monitoring period are given for each patient in table 1. Concentrations varied considerably between the patients.

Ascorbic acid could not be measured in all patients, and in those in whom it was measurable it sometimes varied greatly from sample to sample (see for instance, patients 59 and 61, figs 2 and 3).

Patients who died (GOS 1, n=4), had a mean (SEM) concentration of UA of 113.6 (31) µM, those with a good outcome (GOS 4 or 5, n=3) 17.3 (3.5) µM. This difference was significant (p<0.05, Mann-Whitney U test). Patients with a poor outcome (GOS 2 or 3, n=6) had a mean (SEM) UA concentration of 37.5 (17.8) µM.

Discussion

It is known that there is oxidative stress, resulting in free radical activity, during ischaemia and reperfusion, and after brain trauma.

Free radical scavengers have been shown to be neuroprotective in experimental models of brain injury and ischaemia. Tirilazad, an aminosteroid antioxidant, has been shown to be efficacious in patients with subarachnoid haemorrhage, although it has not been generally recognised as a clinical neuroprotective agent. It would therefore be advantageous to be able to monitor for oxidative stress in patients in critical care. Parabanic acid and glycerol have already been suggested for this purpose. Our aim was to find out if there were changes in concentrations of UA and Asc in patients with severe head injury, which might indicate oxidative stress. There is evidence to support this idea.

Uric acid, which is the end product of purine nucleotide degradation, is an important antioxidant in the body. However, it is also itself one source of reactive oxygen species; during ischaemia and reperfusion, UA arises from xanthine in the presence of xanthine oxidase, together with superoxide radicals. Thus it has been suggested as a marker for free radical activity. Greatly increased UA has been found in cortex tissue both postischaemically and after experimental traumatic brain injury.

Additionally, increased extracellular concentrations were found in rats after middle cerebral artery occlusion; this increase was only moderate at 4 hours but 13-fold after 24 hours. However, this increased UA does not come exclusively from free radical activity; it can also arise from the breakdown of purines in the DNA and RNA of necrotic or apoptotic cells and from breakdown of ATP and adenosine.

Ascorbic acid is also an important antioxidant present in large quantities in the brain. It is a broad spectrum radical scavenger effective against reactive oxygen species. Although Asc, as a water soluble antioxidant, is not able itself to scavenge in the lipid compartment, it can play an important part in maintaining concentrations of the fat soluble vitamin E, a known...
neuroprotective agent for cell membranes. There is also evidence that Asc is involved in excitatory amino acid release and that changes in its extracellular concentrations can be used as an index of such release. It is reduced in the cortex after middle cerebral artery occlusion, and increased in the ECF during ischaemia in both rats and humans. It has been suggested as a biochemical index of early ischaemia. Concentrations of Asc also increase in the ECF after experimental brain trauma.

INTENSIVE CARE

We were able to detect UA in all the patients with trauma. Mean values varied between 6 µM and 180 µM (table 1). The very high concentrations in some patients cannot be explained by the type of injury (CT showing contusion or diffuse injury), as there was no statistical difference between the two groups (Mann-Whitney U test). There was also no correlation with the duration of monitoring (Spearman rank correlation). O’Neill and Lowery reported a sevenfold increase in basal concentration (measured by microdialysis and voltammetry) a few days after probe insertion, in parallel with gliosis around the probe. We did not have any indication of this in our patients, values quite often becoming reduced over time. The very high concentrations in some patients might indicate damage to the blood-brain barrier, or the presence of blood in the brain in the area of probe insertion, as plasma concentrations (around 300 µM) are much higher than CSF concentrations in humans. In one patient where a routine postoperative CT showed a tiny haemorrhage around the probe, we found greatly increased UA values at the end of the operation. There is a tendency for the higher UA values to be associated with a poor outcome. In severely injured patients with a poor outcome there would be increased release of purine metabolites from the nuclei of damaged cells (necrosis or apoptosis). In an experiment using middle cerebral artery occlusion in the rat, we found a significant correlation between lesion size and total UA in microdialysates collected for 3 days after occlusion.

Although we could always measure Asc during operations, it was not possible to detect this variable in every sample during monitoring in the ICU. Indeed, in some patients it could not be detected at all. This might be explained by the fact that in severe head injury and ischaemia there is ongoing peroxidation and all the Asc might be used up. But this cannot be the whole explanation. There are certainly technical difficulties, as Asc is very easily oxidised and dialysates in the ICU are collected for 1 hour without cooling. We also have evidence that Asc is degraded by high concentrations of UA (over 60 µM) in the dialysates (unpublished data). Other authors have also reported some difficulties concerning microdialysis and Asc. Thus in rats, Miele and Fillenz found a true basal concentration of 416 µM (measured by a modification of the zero net flux method), although cortical dialysates in these animals contain maximally about 30 µM. Miele and Fillenz suggest that Asc is continuously oxidised in the efflux from the probe, as the tubing is known to be permeable to gases. We used 0.9% saline as perfusion fluid for our intraoperative measurements. On the other hand, for our critical care patients we used the CMA/600 enzymatic analyser, for which artificial CSF (containing calcium) from CMA/Microdialysis is mandatory. Thus there is a discrepancy in perfusion fluids between our intraoperative and critical care patients, which might affect recovery. However, a recent methodological paper found only minimal differences in concentrations of glucose, lactate, glutamate, and pyruvate during perfusion with Ringer’s solution (containing calcium) or normal saline. This comparison was performed during 24 hours in patients with head injury, using two probes inserted through the same transcranial screw and perfused in parallel with the two fluids.

There are some points of interest in the time courses of the three patients. In patient 59 (fig 2) the clinical course and microdialytic monitoring were uneventful; UA was not excessively high, and glucose, lactate, and glutamate concentrations were normal. Concentrations of UA lessened slowly during the course of monitoring, which might indicate that cell death due to the original trauma was diminishing. However the outcome was poor, the patient remaining severely handicapped. This discrepancy can be explained by the limitations of the monitoring technique. The probe, which can only monitor a limited volume of tissue, was inserted in the cortex, so that it was too far away from the infratentorial injury to detect any relevant changes. By contrast, patient 61 (fig 3) had a satisfactory outcome. In this patient UA decreased markedly, approaching the values found intraoperatively in minimally disturbed tissue, and Asc increased at the end of the monitoring period. This might indicate normalisation of the metabolism as the patient then regained consciousness. The third patient (fig 4) showed the classic picture of ischaemia 48 hours after probe insertion: very high ICP and low CPP combined with glucose diminishing to zero, high lactate, and an enormous rise in glutamate. Initially, UA was very high, indicating massive damage. As in patient 61, UA diminished rapidly (beginning at about 35

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hours). However, in this case the reduction did not indicate normalisation of metabolism as the patient died the next day. It must be attributed to some other mechanism—for example, lack of perfusion or metabolic breakdown. Another possibility might be that UA and Asc (both antioxidants) disappear because of production of free radicals formed by the marked release of glutamate. It has been shown in rats that high extracellular glutamate leads to massive production of free radicals.25

Thus, although our intraoperative results indicate that Asc is affected by ischaemia (increased Asc during retraction, increase in bypass patients) this variable requires further evaluation in patients. It does not seem to be a suitable index for monitoring of conditions of peroxidation in patients in ICUs. This is because it is too unstable and presents problems of collection and analysis, and possibly because the probe is often inserted several hours after the original injury (table 1). Uric acid is stable and easily analyzed. However, alterations in its concentration in the ECF probably reflect long term effects (chronic ischaemia in the bypass patients, neurodegeneration) rather than acute changes in free radical metabolism leading to secondary damage. This fact makes correlation with clinical indices very difficult. However, it is of interest that high concentrations seem to indicate a disturbed metabolic state and are a sign of poor outcome in patients with trauma.

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