RESEARCH NOTE

Wash-in and wash-out of sevoflurane in a test-lung model: A comparison between Aisys and FLOW-i [version 1; referees: 2 approved with reservations]

Petter Jakobsson¹, Madeleine Lindgren², Jan G. Jakobsson²

¹Faculty of Medicine, University of Lund, Lund, 221 00, Sweden
²Department of Anaesthesia & Intensive Care, Institution for Clinical Science, Karolinska Institutet, Danderyds University Hospital, Stockholm, 182 88, Sweden

Abstract

Background: Modern anaesthesia workstations are reassuringly tight and are equipped with effective gas monitoring, thus providing good opportunities for low/minimal flow anaesthesia. A prerequisite for effective low flow anaesthesia is the possibility to rapidly increase and decrease gas concentrations in the circle system, thereby controlling the depth of anaesthesia. Methods: We studied the wash-in and wash-out of sevoflurane in the circle system with fixed fresh gas flow and vaporizer setting. We compared two modern anaesthesia work stations, the Aisys (GE, Madison, WI, USA) and FLOW-i (Maquet, Solna, Sweden) in a test lung model. Results: We found fresh-gas flow to have, as expected, a major influence on wash-in, as well as wash-out of sevoflurane. The wash-in time to reach a stable circle 1 MAC (2.1%) decreased from an average of 547 ± 83 seconds with a constant fresh gas flow of 300 ml/min and vaporizer setting of 8%, to a mean of 38 ± 6 seconds at a fresh gas flow of 4 L/min. There were only minor differences between the two works-stations tested; the Aisys was slightly faster at both 300 and 4 L/min flow. Time to further increase circle end-tidal concentration from 1-1.5 MAC showed likewise significant associations to fresh gas and decreased from 330 ± 24 seconds at 300 ml/L to less than a minute at constant 4 L/min (17 ± 11 seconds), without anaesthetic machine difference. Wash-out was also fresh gas flow dependent and plateaued at 7.5 L/min. Conclusions: Circle system wash-in and wash-out show clear fresh gas dependency and varies somewhat between the Aisys and Flow-i. The circle saturation, reaching 1 MAC end-tidal or increasing from 1-1.5 MAC can be achieved with both work-stations within 1.5 minutes at a constant fresh gas flow of 2 and 4 L/min. Wash-out plateaued at 7.5 L/min.
Corresponding author: Jan G. Jakobsson (jan.jakobsson@ki.se)

How to cite this article: Jakobsson P, Lindgren M and Jakobsson JG. Wash-in and wash-out of sevoflurane in a test-lung model: A comparison between Aisys and FLOW-i [version 1; referees: 2 approved with reservations] F1000Research 2017, 6:389 (doi: 10.12688/f1000research.11255.1)

Copyright: © 2017 Jakobsson P et al. This is an open access article distributed under the terms of the Creative Commons Attribution Licence, which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited. Data associated with the article are available under the terms of the Creative Commons Zero "No rights reserved" data waiver (CC0 1.0 Public domain dedication).

Grant information: The author(s) declared that no grants were involved in supporting this work.

Competing interests: No competing interests were disclosed. Jan Jakobsson, have however previously received research grants for previous research activities from Maquet, Abbott, Baxter, MSD, Phitzer, Nycomed, Phaseln, Grunenthal. He has been lecturing and taken part in advisory board activities for Maquet, Abbott, Baxter, MSD, Phitzer, Nycomed, Phaseln, Masimo, Grunenthal. He has a paid consult agreement with Linde Healthcare as safety physician.

Introduction
A rapid change in inspired anaesthetic agent is a requisite for the control of the depth of anaesthesia. Low flow anaesthesia has been increasingly adopted, as it is associated with several benefits, including conserving humidity and temperature, which improves the quality of anaesthesia. Reducing the amount of anaesthetic agent consumed is of interest not only for reducing cost, but also for reducing environmental burden. The merits of reducing flow must not overrule safety, by maintaining adequate oxygen content in the circle, and avoiding hypoxic gas mixture, inadequate anaesthesia control and too light anaesthesia with risk for awareness.

Methods
The two anaesthetic workstations, Aisys (GE Healthcare, Madison, WI, USA) and FLOW-i (Maquet, Solna, Sweden), including a standard CO₂ absorber and a standard circle system (patient circuit, adult, disposable 1.8 m; GE Healthcare) and a Humid-Vent Filter (Teleflex, Wayne, PA, USA), were connected to a 2 L elastic test reservoir (Intersugical Ltd., East Syracuse, NY, USA).

Wash-in: time to reach a stable circle concentration; end-tidal concentration of 1 and 1.5 MAC age adjusted (40 year old male) sevoflurane (2.1 and 3.1%) was studied with the circle connected to the test reservoir. The ventilation was set at tidal volume 500 ml, respiratory rate 10 and PEEP 5 cmH₂O, for both devices. The oxygen fraction was set at 0.4. Fresh gas flow was fixed at 300, 500, 1000, 2000 and 4000 ml/minute. The vaporizer setting was fixed at 8% for both devices during the wash-in.

The time to reach 1 MAC and the time to increase from 1-1.5 MAC circle concentration was recorded for each value, based on mean of 3 repeated tests.

Wash-out: time to decrease from 1.5 MAC to 0 gas concentration with a fixed fresh gas setting of 2500, 5000, 7500 and 10000 ml/minute.

Statistics
All data are presented as mean and standard deviation based on 3 – 5 repeats. The effects on time events (wash-in: increase from 0 – 1 MAC and further increase up to 1.5 MAC; wash-out: decrease from 1.5 MAC to 0 gas) between fresh gas flows and anaesthetic work-stations were calculated by ANOVA. P<0.05 was considered to be statistically significant. Data was analysed with StatView (v1.04) for MAC.

Results
Fixed fresh gas flows had a significant impact on the speed of wash-in - time to achieve a stable circle end-tidal sevoflurane concentration of 1 MAC age adjusted (2.1%). The mean time of both machines decreased from 547 ± 83 seconds, at a fixed fresh gas flow of 300 ml/min and fixed vaporizer setting of 8%, to 38 ± 6 seconds at a fresh gas flow of 4000 ml/min. The time to further increase the circle system end-tidal sevoflurane from 1 to 1.5 MAC also showed a significant dependency on fresh gas flow: 330 ± 24 seconds, at a fixed fresh gas flow of 300 ml/min and fixed vaporizer setting of 8%, to 17 ± 11 seconds at a fresh gas flow of 4000 ml/min.

Both anaesthetic work-stations showed the same fresh-gas flow dependent for wash-in and wash-out pattern, but the Aisys showed overall a slightly faster wash-in time (Table 1 and Figure 1).

<table>
<thead>
<tr>
<th>Vaporizer</th>
<th>L/min</th>
<th>0.3</th>
<th>0.5</th>
<th>1</th>
<th>2</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>FLOW-i</td>
<td>0-1</td>
<td>618</td>
<td>342</td>
<td>141</td>
<td>75</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>1-1.5</td>
<td>317</td>
<td>191</td>
<td>88</td>
<td>46</td>
<td>25</td>
</tr>
<tr>
<td>Asysis</td>
<td>0-1</td>
<td>477</td>
<td>232</td>
<td>99</td>
<td>48</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td>1-1.5</td>
<td>344</td>
<td>165</td>
<td>96</td>
<td>22</td>
<td>10</td>
</tr>
</tbody>
</table>
Table 2. Wash-out time (seconds) to decrease from 1.5 MAC circle concentration with a constant fresh gas flow and closed vaporizer. Tidal volume 500 ml, respiratory rate 10, PEEP 5 and volume controlled ventilation.

<table>
<thead>
<tr>
<th>L/min</th>
<th>2.5</th>
<th>5</th>
<th>7.5</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aysis</td>
<td>15.41</td>
<td>4.25</td>
<td>2.14</td>
<td>2.15</td>
</tr>
<tr>
<td>FLOW-i</td>
<td>10.73</td>
<td>4.45</td>
<td>2.49</td>
<td>2.48</td>
</tr>
</tbody>
</table>

(22 ± 3 and 46 ± 3 seconds for Asysis and Flow-i, respectively) at a fixed fresh gas flow of 2000 ml/min. When a 4000 ml/min was used, the monitoring system not fast enough to catch the increase for the Aisys, but recorded the increases as 25 ± 10 seconds for Flow-i.

Wash-out was likewise flow dependent, and plateaued at 7.5 L/min (Table 2 and Figure 2).

![Figure 1. Wash-in time (minutes) to increase to 1 MAC (sevoflurane 2.1%) for (A) Aysis and (B) FLOW-i anaesthetic work stations.](image)

Dataset 1. Raw data from the wash-in increase of Et-sevoflurane at fixed fresh gas flow and vaporiser setting

http://dx.doi.org/10.5256/f1000research.11255.d156064
Discussion
The present study was set-up to evaluate the impact of fresh gas flow on saturation of and wash-out from the circle system/test-lung set up and whether the modern anaesthesia machines performed differently. We found a clear fresh-gas flow dependency for the time to saturate and wash-out of the circle and test-lung system, as expected. Wash-in to 1 MAC and further increasing the circle concentration to 1.5 MAC decreased with the fresh gas flow, and a 1 and further increase to 1.5 MAC was achieved within 1 minute at a fresh gas flow of 4 L/min. The wash-out was not further improved between 7.5 and 10 L/min fresh gas flow.

We found somewhat surprisingly that the Aisys was slightly faster than the FLOW-i, although the FLOW-i should have a small internal gas reservoir. Lucangelo et al. studied the FLOW-i performance regarding tidal volume in case of minor leakage. They found the system to be highly accurate. They also described the gas flow control in detail addressing the technical features of the flow regulators. Thus, our hypothesis was a faster saturation of the circle gas with the FLOW-i technology.

Dosch et al. studied the change in circle gas composition in three anaesthetic machines and found that fresh gas flow and breathing system volume have the biggest effect on time to equilibrium. In a previous study, we analysed the wash-in of desflurane and sevoflurane during fixed fresh gas flow and vaporizer setting with the Aisys anaesthesia workstation. We found, as expected, desflurane to be associated to a significantly faster wash-in compared to sevoflurane with a significant impact from the fresh gas.

Figure 2. Wash-out time (minutes) for decrease from 1.5 to 0 MAC with sevoflurane at 3.1-0% in (A) Aysis and (B) FLOW-i anaesthetic work stations.
flow: The increase from 0.5 L/min to 1.0 L/min in fresh gas flow reduced the time to reach 1 MAC age adjusted end-tidal concentration from 15.2±2.4 minutes to 6.2±1.3 minutes. We found in that study a rather large variability for sevoflurane, which we considered was related to a combination of circle system gas saturation and uptake.

Kern et al. studied the saturation of neonatal anaesthesia systems\textsuperscript{vii}. They found huge differences in the time to reach the end tidal concentration above 95\% of inspired. They also found wash-in times to decrease with higher fresh gas flows and higher minute ventilation rates; however, they saw that the effect of doubling fresh gas flow was variable and less than expected. Stryu et al. made a study much like ours comparing the Zeus apparatus with direct injection of inhaled anaesthetics and the Primus apparatus using a classical out-of-circle vaporizer\textsuperscript{viii}. They found the Zeus to have a faster time course, but their study set-up was different from ours; they used fresh gas and auto control modes, providing a high initial fresh gas bolus. We compared the novel FLOW-i with a similar injection technique and without classical reservoir, and the Aysis with a more classic design. Carette et al. studied the performance of the automatic control mode of the FLOW-i\textsuperscript{x}. The possibility to use an automatic algorithm to reach desired circle, end-tidal concentration is an interesting option and we plan to do further studies assessing the automatic technique. One limitation of the study was that it is an entirely experimental study.

In conclusion, wash-in, saturation of and wash-out of the circle system is fresh gas flow dependent. A 1 MAC can be reached within 1 minute at a fixed vaporizer setting of 8 at a fresh gas flow of 4 L/min and further increase from 1-1.5 MAC can be reached within 1 minute at a fresh gas flow of 2 L/min. Wash-out was found likewise flow dependent, but the time to reach a zero end-tidal concentration plateaued at 7.5 L/min.

### Ethical statement
This is a test model study. The research does not involve human participants and/or animals, and thus no informed consent has been requested. The set-up is entirely experimental and no human or animals have been exposed to anaesthetics, and thus no ethical review board assessment has been considered necessary.

### Data availability
Dataset 1: Raw data from the wash-in increase of Et-sevoflurane at fixed fresh gas flow and vaporiser setting. doi, 10.5256/f1000research.11255.d15606\textsuperscript{v}

Dataset 2: Raw data from the wash-out of Et-sevoflurane at zero vaporiser setting and increasing fresh gas flow. doi, 10.5256/f1000research.11255.d156065\textsuperscript{v}

### Author contributions
All authors have contributed equal to study design, set up, conduct of experiments, analysis, compilation, and preparation of manuscript.

### Competing interests
No competing interests were disclosed.

Jan Jakobsson, have however previously received research grants for previous research activities from Maquet, Abbott, Baxter, MSD, Phitzer, Nycomed, PhaseIn, Grunenthal. He has been lecturing and taken part in advisory board activities for Maquet, Abbott, Baxter, MSD, Phitzer, Nycomed, PhaseIn, Masimo, Grunenthal. He has a paid consult agreement with Linde Healthcare as safety physician.

### Grant information
The author(s) declared that no grants were involved in supporting this work.

### References


The authors have examined the effect of fresh gas flow rates on the wash-in and wash-out of a single volatile anaesthetic agent in two modern anaesthetic workstations under experimental conditions. The investigation is essentially in two parts. The first shows that wash-in and wash-out and flow dependent for both anaesthesia machines. As these are exponential processes, this finding is entirely predictable and rapid wash-in (or wash-out) will only be achieved at fairly high fresh gas flow rates, whatever the internal design of the anaesthetic machine. While it is still important to define optimal flow rates for new equipment, this part of the paper does not really provide any very new information.

The second part of the study is potentially far more interesting and this is the comparison between the two systems. The authors speculated, quite appropriately in my opinion, that wash-in and wash-out would be faster with the Flow-i system due to its lower internal volume. However, they did not find this to be the case, especially with regard to wash-in where, in fact, the Flow-i was actually the slower of the two systems. What I find very disappointing is that the authors do not really address why they did not obtain the results they anticipated. Although their discussion mentions a few related points, there is almost nothing concerning the differences between the two systems studied or what the implications of these findings might be. The authors also seem not to have commented on the fact that differences between the two machines were not consistent between wash-in and wash-out and whether this provides any insight into the observed results. For me, this would be a far more interesting paper if these differences were explored in a bit more detail. I would also be interested to know if I needed to change the way I altered vapouriser settings and flow rates in practice were I to switch from one of these systems to the other.

One possible explanation for the apparent differences has already been mentioned in a previous review, namely that there was not really a difference at all, but that using the in-built gas analysers of the machines resulted in apparent differences due to differences in sampling times/mechanisms/algorithms. I also wonder if differences in the vapouriser technology might explain the findings, at least in part. According to the Maquet user's manual, during controlled ventilation “a larger proportion of the fresh gas is added during the inspiration phase, also contributing to minimising agent consumption”. Our technical staff tell me that the Flow-i vapouriser only injects anaesthetic agent during inspiration and is inactive during the expiratory phase of the cycle. If this is correct, and if the Aisys delivers vapour continuously, like a conventional vapouriser, that might explain why wash-in to a test lung is slower than expected. It is also likely under those circumstances that the difference between the machines would be reduced if higher respiratory rates were used and might also be completely different during spontaneous ventilation. Do the authors have detailed knowledge of how the two vapouriser systems function?
Although the Flow-i, unexpectedly, was slower than the Aisys, this was not consistently observed and again I think this deserves some discussion. For wash-in from 0–1 MAC, the Aisys was consistently faster, with times ranging from 64–79% those of the Flow-i. However, for wash-in from 1–1.5 MAC, the times were much less consistent, ranging from 109% to 40% those of the Flow-i. Neither was any pattern evident for the second stage wash-in, with the Aisys actually being slower at 0.3 and 1 l/min, but faster at 0.5, 2 & 4 l/min. Can the authors explain this at all? Could sampling error be enough to explain the differences?

The wash-out results are even more confusing. The Flow-i was slower from 5 to 10 litres/minute, but the wash-out times were so fast that the differences are small and probably within the limits of sampling error. However, at 2.5 l/min the Flow-i was 70% faster. This faster wash-out is entirely consistent with the lower internal volume of the Flow-i (as hypothesised by the authors) and, to me, lends support to the concept that the unexpected observations during wash-in are probably related to differences in the function of the vapourisers.

As the authors state, this was a test model study. However, the results are likely to be used to inform clinical practice. The problem is that the results are unlikely to be reproduced in clinical practice. As the authors used a test lung, there was no uptake of anaesthetic vapour from the breathing circuit. Adding a patient compartment is likely to delay the wash-in of the anaesthetic machine compartment due to uptake of anaesthetic. This should affect both machines to a similar degree, although if the Flow-i preferentially injects vapour during inspiration while the Aisys does not, it is possible that the addition of a patient may affect the systems differently. Wash-out will also be delayed by the addition of anaesthetic vapour to the breathing system from the patient's lungs. This should affect both systems equally, but in this case will differ with the duration of anaesthesia delivery and hence the amount of agent taken up by the patient. Do the authors have any clinical data to indicate by how much their findings are actually altered in clinical practice?

A few other comments:
What determined the number of repeat measurements? In the methods it is stated wash-in times were determined “based on [the] mean of 3 repeated tests”, but in the statistics section it is said data are means “based on 3–5 repeats”.

It is stated that data are shown as means and standard deviation. However, all of the tables and figures show only mean data. Standard deviations are only given for the data specifically highlighted in the main text. Without standard deviations, the degree of imprecision of the data cannot be assessed.

Although a statistically significant p value is defined, the authors do not state the minimum size of differences which they considered to be clinically important. In a few cases, the differences are only a few seconds and of little consequences, but in quite a few cases, the differences are 100 seconds or more and represent quite large percentage differences between the systems. An indication of a minimal clinically-important difference, in association with an indication of the degree of variability, would greatly aid interpretation of the results.

Statistical tests have been applied to the differences in wash-in and wash-out for both systems (combined) at high versus low gas flows, even though these differences are large in magnitude and highly predictable. However, statistical tests do not appear to have been reported for the far more interesting differences between the anaesthesia machines at each flow rate.

Is the work clearly and accurately presented and does it cite the current literature?
Partly

Is the study design appropriate and is the work technically sound?
Partly

Are sufficient details of methods and analysis provided to allow replication by others?
Yes

If applicable, is the statistical analysis and its interpretation appropriate?
Partly

Are all the source data underlying the results available to ensure full reproducibility?
Yes

Are the conclusions drawn adequately supported by the results?
Partly

**Competing Interests:** No competing interests were disclosed.

I have read this submission. I believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard, however I have significant reservations, as outlined above.

Referee Report 13 April 2017

doi:10.5256/f1000research.12142.r21357

Göran Hedenstierna
Hedenstierna Laboratory, Department of Medical Sciences, Clinical Physiology, Uppsala University, Uppsala, Sweden

This is a straightforward and simple, in a good sense, model study on the wash-in and wash-out of an anesthetic gas in a test lung model. Comparison has been made between two commercially available anesthesia machines, Aisys and Flow-i. A major finding was that with increasing gas flow, wash-in and wash-out times were reduced, as might be anticipated. The difference was small between the two anesthesia machines but there was a slight difference that in itself was unexpected, i.e. the Aisys being a little faster than the Flow-i. The Aisys uses conventional reservoir bag whereas the Flow-i uses an internal reflector that, at least in theory, should reduce any dead space effect and thus shorten time constants in gas dynamics.

I have some comments.

Firstly, the wash-in and wash-out times have been measured in a lung model, the same for both anesthesia machines but the gas concentration has been measured with built in equipment in the Aisys and Flow-i and thus different for the two anesthesia machines. At least I interpret of the results this way. This means that there might be a difference in results that are not caused by the different techniques of internal gas reservoir. With different gas analyzers the results may be related to how the analyzers have been calibrated and what algorithms have been used. Ideally, one should use the same gas analyzer for
both machines if the intention has been to test the effect of the design of the gas reservoir. This is my major comment and I suggest that the gas analyzers should be compared to an independent reference. Other comments follow below.

Abstract line 14: 300 ml/min.
Methods, wash in: You might have used additional settings of the ventilator such as tidal volume, respiratory rate and PEEP. At least you might discuss this.
Results, page 4 line 3 under figure 1: was not fast enough.
Discussion, page 5, third last line in the right column: Why as expected?
Page 6, left column, second paragraph: Zeus

Is the work clearly and accurately presented and does it cite the current literature?
Yes

Is the study design appropriate and is the work technically sound?
Partly

Are sufficient details of methods and analysis provided to allow replication by others?
Partly

If applicable, is the statistical analysis and its interpretation appropriate?
Yes

Are all the source data underlying the results available to ensure full reproducibility?
Yes

Are the conclusions drawn adequately supported by the results?
Partly

**Competing Interests:** No competing interests were disclosed.

I have read this submission. I believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard, however I have significant reservations, as outlined above.

---

**Author Response (Member of the F1000 Faculty and F1000Research Advisory Board Member) 13 Apr 2017**

**Jan Jakobsson,** Department of Physiology and Pharmacology, Karolinska Institutet, Sweden

Dear Referee

**Thank you for comments;**
We acknowledge the limitation using the machine gas monitor. Both machines are equipped with "standard" side-stream multi-gas monitors. These instruments have an internal calibration at start up. We did perform a startup prior to each test. It should also be noticed that we performed the study with standard anaesthetic machines used at our department, machines used for ordinary patient care. We performed the test during late afternoons and evenings. Thus we do expect the IR-multi-gas readings to be adequate.
Abstract line 14: 300 ml/min.
There is indeed a text error in the abstract line 14 please excuse, should read 300 ml/min. no doubt

The ventilator settings are presented in the methods section; The ventilation was set at tidal volume 500 ml, respiratory rate 10 and PEEP 5 cmH2O, for both devices.

Results, page 4 line 3 under figure 1: much agree, the was is indeed missing, please excuse

Discussion, page 5, third last line in the right column: Why as expected?
This is simply because all authors are clinically active and we are so used to see the lower solubility benefit and subsequently faster "blood compartment wash-in" associated to desflurane as compared to sevoflurane. This can indeed be argued when looking merely at circle system equilibration/wash-in. Thank you for most adequate comment.

Page 6, left column, second paragraph: Zeus,
This refers to the Zeus anaesthesia apparatus (Dräger, Lubeck, Germany)

I hope our comments/responses are acceptable and your adequate and effective review.

Best regards
Jan Jakobsson, on behalf of all authors

**Competing Interests:** None