SCIENTIFIC ARTICLE

Comparison of waste anesthetic gases in operating rooms with or without an scavenging system in a Brazilian University Hospital

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Abstract

Background and objectives: Occupational exposure to waste anesthetic gases in operating room without active scavenging system has been associated with adverse health effects. Thus, this study aimed to compare the trace concentrations of the inhalational anesthetics isoflurane and sevoflurane in operating room with and without central scavenging system.

Method: Waste concentrations of isoflurane and sevoflurane were measured by infrared analyzer at different locations (near the respiratory area of the assistant nurse and anesthesiologist and near the anesthesia station) and at two times (30 and 120 min after the start of surgery) in both operating room types.

Results: All isoflurane and sevoflurane concentrations in unscavenged operating room were higher than the US recommended limit (2 parts per million), regardless of the location and time evaluated. In scavenged operating room, the average concentrations of isoflurane were within the limit of exposure, except for the measurements near the anesthesia station, regardless of the measurement times. For sevoflurane, concentrations exceeded the limit value at all measurement locations and at both times.

Conclusions: The exposure to both anesthetics exceeded the international limit in unscavenged operating room. In scavenged operating room, the concentrations of sevoflurane, and to a lesser extent those of isoflurane, exceeded the recommended limit value. Thus, the operating room scavenging system analyzed in the present study decreased the anesthetic concentrations, although not to the internationally recommended values.

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Introduction

Occupational exposure to residual concentrations of inhaled (volatile) anesthetics in operating rooms (ORs) without scavenging system has been associated with adverse health effects, such as headache, irritability, neurobehavioral changes, and DNA damage.1

Although the cause-and-effect relationship has not yet been established, agencies in several developed countries recommend limit values for exposure to anesthetic gases to minimize health risks. The US National Institute of Occupational Safety and Health (NIOSH)2 recommends the value of 2 parts per million (ppm) as occupational exposure limit to halogenated inhalational anesthetics.

Halogenated anesthetics are the most widely used agents in inhalational anesthesia worldwide. An anesthetic power measure refers to the minimum alveolar concentration (MAC). In adult patients, the halogenated sevoflurane has a MAC of about 2%, which is higher than that of isoflurane (1.2%).3

The use of inhalational anesthetics requires a scavenging system to reduce both the OR environmental contamination and occupationally exposed professionals. However, adequate OR scavenging systems are uncommon in most hospitals in developing countries. Even with the presence of an OR scavenging system in these countries, there are still large differences in efficiency between systems in developed and developing countries.4

Due to the subject relevance and the absence of national data, this unpublished work aimed to compare the residual concentrations of isoflurane and sevoflurane in ORs with and without an anesthetic gas scavenging system in a public university hospital.

Method

This study was approved by the local Research Ethics Committee (4440-2012) and performed in a hospital with a theater setting of 13 ORs, seven of which without a scavenging system, with only one air conditioner, and six with a (partial) scavenging system with only 25% of clean external air (thus, with 75% air recirculation), with seven air changes per hour. Regarding the anesthesia stations, there was no scavenging system exclusive to inhalational anesthetics.

The study was performed in the ORs, always with the measurement of anesthetic residues during the first general anesthesia of the day, under anesthesia maintenance with isoflurane or sevoflurane, in 24 patients with tracheal intubation with cuffed tube, which was filled with minimum seal pressure to avoid leakage during artificial ventilation.

Both isoflurane and sevoflurane concentrations were used around 1 MAC, according to patient’s need, with fresh gas flow (FGF) of 2 L min⁻¹ in circular breathing circuit with CO₂ absorber, according to the standard procedures of our hospital. The anesthesia workstation Dräger Fabius GS Premium (Germany) was used in all ORs.
A portable anesthetic gas analyzer (InfraRan 4-Gas Anesthetic Specific Vapor Analyzer, Wilks Enterprise, USA) was used to measure the residual concentrations of both anesthetics. The analyzer detects the anesthetic concentration in real time by infrared, and the equipment detection limit ranges from 0 to 50 ppm for halogenated anesthetic agents. Air samples were measured in three sites: the anesthesiologist and nursing assistant breathing areas and near the anesthesia workstation breathing circuit (Figs. 1 and 2). Samples were collected at two times: 30 and 120 minutes (min) after the start of surgery.

Mean residual concentrations were calculated for each inhalational anesthetic at both times, at the three measurement sites and according to the OR type. Student’s t test was used to compare times, OR types, and anesthetics. ANOVA was used to compare the measurement sites for each anesthetic, each time and type of OR. Significance levels lower than 5% were considered significant.

Results

Table 1 shows the mean residual concentrations of isoflurane and sevoflurane measured in OR. Regarding the measurement sites, the residual concentration values in the nursing assistant and anesthesiologist breathing areas, as well as in the anesthesia workstation, were not different for both anesthetics, regardless of the OR type ($p > 0.05$), with the highest values close to the anesthesia workstation.

Concentrations of both anesthetics were higher in ORs without scavenging system in all sites and times measured compared to those in ORs with scavenging system

Discussion

The present study demonstrated that: (i) the use of isoflurane and sevoflurane in ORs without an anesthetic gas scavenging system resulted in mean residual concentrations that largely exceeded the 2 ppm values recommended by NIOSH; (ii) ORs with scavenging system showed mean residual isoflurane concentrations lower than that recommended by NIOSH at two of the three measurement sites; (iii) ORs with scavenging system showed mean residual sevoflurane concentrations that exceeded the NIOSH recommended limits at all sites measured.

Thus, monitoring the concentrations of halogenated anesthetic gases in OR with and without a scavenging system, as evidenced in our study, demonstrated the fundamental role of a scavenging system to remove anesthetic gas from ORs, reducing both anesthetic pollution and occupational exposure, particularly regarding isoflurane. Modern OR scavenging systems consist of a laminar flow system with at least 15 air changes per hour, without air recirculation. With the use of appropriate scavenging systems, literature
has shown that mean concentrations of isoflurane and sevoflurane residues were below 2 ppm. However, the anesthetic gas scavenging system present in the ORs of our surgical theater is considered partial, as it generates only seven air changes per hour, with air recirculation, with turbulent flow system. Thus, this less effective technology may explain the higher observed residual concentrations of sevoflurane, but not isoflurane. Due to its low anesthetic potency, the administration of sevoflurane should be done at MAC twice that of isoflurane, which increases the possibility of a greater residual concentration of this agent in the ORs.

Inhalational anesthetics leakage from the anesthesia workstation may also have contributed to the residual anesthetic concentrations. In fact, the highest concentrations of sevoflurane and isoflurane were found near the anesthesia workstation breathing circuit, although there were no leaks from the Dräger Fabius anesthesia workstation. It should also be considered that the more modern anesthesia workstations are likely to have less leakage, as there is a need to perform the leakage test before using the equipment. Other causes of OR contamination include failure to shut down the flow control valves, flushing the breathing circuit with high FGF, leakage of inhaled anesthetics during filling of vaporizers, use of uncuffed tracheal tube, and use of high FGF (≥3 L min⁻¹).

Indeed, more efforts are needed to reduce exposure to inhalational anesthetics. Frequent monitoring of anesthetic gas residual concentrations in ORs should be the first step toward understanding the values of occupational exposure in the workplace. The proper installation and operation of the OR scavenging system and use of new anesthesia workstations, as well as staff training, are also important to reduce the levels of occupational exposure. Moreover, reducing FGF (≤1 L min⁻¹) is especially important in an environment without an active scavenging system. In addition, the replacement of inhalational anesthetics by venous anesthetics, when possible, should be done in the absence of an adequate system to remove anesthetic gas residues in a surgical theater.

In conclusion, our study demonstrated high residual concentrations of isoflurane and sevoflurane in ORs without a scavenging system, which considerably exceed the values recommended by international agencies. In ORs with a partial scavenging system, the halogenated anesthetic concentrations are lower than in ORs without a scavenging system, but the exposure, particularly to sevoflurane, still exceeds the recommended limit.

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Conflicts of interest
The authors declare no conflicts of interest.

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