

The need for inotropic drugs in anesthesiology and intensive care

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The management of the failing heart represents an increasingly frequent challenge to both anesthesiologists and intensive care physicians, due to the increased prevalence of ventricular dysfunction in the population and to the ever-expanding indications for the surgical treatment of cardiac disease. Inotropic drugs are nowadays invaluable therapeutic tools in the treatment of perioperative heart failure and of the different forms of heart failure found in intensive care unit clinical practice. Postoperative myocardial dysfunction is a major concern in the setting of cardiac surgery since it is extremely frequent and is related to a greater morbidity and mortality. The different forms of heart failure, the rationale and the indications for the use of inotropic drugs in anesthesiology and intensive care are discussed in this review.

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Perioperative heart failure is nowadays a major clinical problem, and perioperative cardiac morbidity is the leading cause of death following surgery and anesthesia¹. As a result of the demographic changes in western populations, steadily moving towards an increase in average age, the number of patients with extensive cardiovascular disease presenting for both cardiac and non-cardiac surgery has dramatically grown. Moreover, an increasing number of sicker and older patients with ventricular dysfunction is now undergoing cardiac surgery because of the ever-expanding indications for surgical intervention, supported by continuous technological improvements: patients with a more impaired ventricular performance, less correctable fundamental disease and highly unstable preoperative states are being increasingly submitted to surgery, and cardiac surgery in octogenarians is no longer an exception^{2,3}. Finally, specific requirements and procedures of cardiac surgery, aimed at achieving a bloodless surgical field and a quiescent heart, constitute an inevitable additional insult to the heart.

Demographic and epidemiological changes in the population have analogous implications in the context of intensive care medicine. The increasing prevalence of congestive heart failure in the population⁴ determines a more frequent finding of this severe comorbidity even in patients requiring crit-

ical care for other indications. A particular pattern of myocardial dysfunction may also be observed in septic shock patients⁵. Obviously, the same considerations about the intraoperative management of heart failure regard the postoperative care of the cardiac surgical patient. For all of these reasons, the management of the failing heart (either acute or chronic with a superimposed acute event) represents an increasingly frequent challenge to the intensive care physician and even more to the anesthesiologist. Pharmacological research has over many years yielded important therapeutic tools to be employed in these settings.

Inotropic drugs in non-cardiac surgery

In the setting of non-cardiac surgery, there obviously is less need for intravenous inotropes. Modern anesthesia (both intravenous and inhalatory) creates a particular status (protection from pain reflexes, blunting of the sympathetic response, vasodilation) which is beneficial to the failing heart. Nevertheless, the use of inotropes may be required in case of⁶:

- atrioventricular or sino-atrial blocks (especially in the elderly or in patients with pre-existing conduction system disease): the use of chronotropic drugs (isoproterenol) when pacing is not available or feasible;

- urgency/emergency surgery, or elective major surgery (hepatic, vascular), in patients with hemodynamic derangement determining an insult to a heart with an unknown reduced coronary reserve, or with preexisting valvular disease;
- elective or urgent major vascular surgery (thoracic or abdominal aortic surgery) in patients with known chronic heart failure, in whom aortic clamping procedures may give rise to an excessive afterload for the failing heart;
- myocardial dysfunction in septic shock patients admitted to surgery;
- perioperative pulmonary thromboembolic complications.

Patients with a reduced/depressed systolic heart function will otherwise (in the majority of non-cardiac surgical settings) benefit from vasodilation and protection from sympathetic responses determined by anesthetic drugs. The anesthetic management will obviously focus on the proper monitoring of the cardiac function and on the optimization of preload, afterload and eventually on heart rate and rhythm, but rarely resort to inotropic drugs. Postoperative management may also require monitoring in an intensive care setting. There might be, in some cases of excessive vasodilation, the need for vasoconstrictors rather than inotropes, in order to maintain an adequate coronary perfusion pressure.

Inotropic drugs in cardiac surgery

Postoperative myocardial dysfunction. A significantly impaired ventricular performance is a common occurrence after cardiac surgery, both in patients with a normal or abnormal preoperative ventricular function⁷⁻¹⁰. Along with a decreased cardiac index, even the right and left ventricular ejection fractions may be decreased to 35 to 75% of their pre-cardiopulmonary bypass (CPB) levels. In fact, current techniques used to achieve an optimal surgical environment include the use of CPB, the infusion of cardioplegia solutions with intervening peri-

ods of ischemia and reperfusion of the previously ischemic heart after aortic cross-clamp removal. Since many years, several factors have been found to contribute to myocardial dysfunction secondary to cardiac surgical procedures: the ischemic insult of aortic cross-clamping¹¹, inadequate myocardial protection¹², hypothermia with cardioplegia and topical iced solutions¹², surgical trauma, inadequate surgical repair, activation of the complement cascade by CPB¹³, reperfusion injury¹⁴, premature or excessive titration of inotropic agents¹⁵. The very techniques used to avoid perioperative injury may thus themselves contribute to this complication.

The postoperative ventricular dysfunction following cardiac surgery is quite similar to, and may be termed as a form of, myocardial stunning: a myocardial dysfunction following a brief ischemic event, unassociated with morphologic injury (necrosis), and thus reversible after a period of convalescence^{16,17}. The heart undergoing this type of surgery is in fact subjected to ischemic and reperfusion injury at multiple points during the operation¹⁸, resulting in various degrees of cytosolic calcium accumulation, free oxygen radical generation, and myocyte and myocardial edema. Although originally observed in the regionally ischemic myocardium after temporary coronary occlusion¹⁹, post-surgical stunning includes both regional and global dysfunction, since regional wall motion abnormalities have an impact on the global performance, and aortic cross-clamping and cardioplegic arrest actually determine a controlled global ischemia. In contrast to regional stunning, which is mainly unilateral, post-surgical stunning may involve both the right and left ventricles^{7,20,21}.

Weaning from CPB represents a critical phase in which the eventual ventricular dysfunction may fully appear, and inotropic drug support may be required. Many studies have in the past identified and monitored systolic myocardial dysfunction during the first hours to days following cardiac surgery. A biphasic pattern of depression occurs (Fig. 1): the recovery from the initial compromise after having weaned from CPB is followed

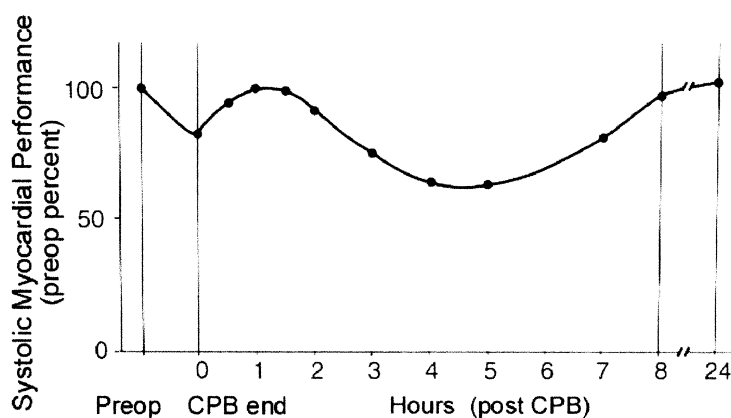


Figure 1. Recovery pattern of cardiac function: postoperative changes in the systolic myocardial performance after heart surgery in patients undergoing cardiopulmonary bypass (CPB), shown as the percentage of the preoperative myocardial performance. Adapted from Royster²².

by a second period of low myocardial performance which reaches its nadir 3 to 6 hours after weaning from CPB. The time to full recovery is usually 8 to 24 hours, but the return to baseline function is often delayed in patients with a worse preoperative ventricular function²⁰⁻²². This knowledge is really important in deciding whether or not to begin inotropic therapy (for example in a patient with an adequate, but borderline, ventricular performance immediately after weaning from CPB), and in the timing of weaning from inotropic support (once required, it should be maintained for at least 10 to 12 hours, or much longer in patients with a poor preoperative function).

Postoperative ventricular dysfunction does not only influence the systolic performance. After CPB, the compliance and relaxation properties of the left ventricle may be decreased, and the diastolic pressure-volume relationship shifted upward, with an inadequate ventricular filling or, at least, adequate filling at the expense of elevated filling pressures^{23,24}, predisposing to a decreased coronary blood flow and compromised subendocardial perfusion. More commonly, diastolic dysfunction results as a consequence of the inability of the left ventricle to empty, but some patients may present with this problem as the predominant factor contributing to the low cardiac output after CPB²⁵. This is particularly true in patients with marked left ventricular hypertrophy (hypertrophic obstructive cardiomyopathy, aortic stenosis, hypertensive cardiomyopathy) in whom the effects of CPB and aortic cross-clamping may dangerously exacerbate a preexisting diastolic dysfunction.

In addition to myocardial stunning and the disease process for which the surgery is being conducted, other factors may contribute to the postoperative ventricular dysfunction with further acute ischemic injury: unfortunate events before the institution of CPB (severe hypotension secondary to pump failure, tachycardia, ventricular fibrillation, other arrhythmias, failed angioplasty with dissection or pre-occlusion), inadequate cardioplegia delivery (inappropriate technique, native vessel stenosis), ventricular distension, incomplete revascularization, and surgical complications (inadvertent coronary lesions, graft lumen obstructions).

Predictors of the need of inotropic support. Several studies have found a correlation between pre- and intraoperative factors and inotropic drug requirements, both in coronary artery bypass and other cardiac surgery^{7,20,22,26-29}. A poor left ventricular function continues to be the most important predictor of a postoperative low output syndrome and of the necessity of inotropic drugs. Other widely recognized predictors are older age, a prolonged aortic cross-clamping and the indices of preoperative ventricular dysfunction (Table I)^{6,19,21,26-28,30}. However, some patients not meeting any predictive criteria fail to satisfactorily wean from CPB in spite of the various predictors currently used.

Table I. Predictive factors of inotropic support, as highlighted by several studies^{6,19,21,26-28,30}.

Low ejection fraction (< 45%)
History of congestive heart failure
Cardiomegaly
High LVEDP following ventriculogram
MI within 30 days of operation*
Older age (> 70 years)
Longer duration of aortic cross-clamping
Prolonged cardiopulmonary bypass*
Urgent operation
Re-operation*
Female gender*
Diabetes mellitus*

LVEDP = left ventricular end-diastolic pressure; MI = myocardial infarction. * statistical significance for coronary artery bypass surgery only.

Four main factors must anyway be taken into account when considering the use of an inotropic drug, as they closely interact in determining the magnitude of postoperative heart failure and the difficulty in weaning from CPB (Fig. 2): 1) the extent of preexisting ventricular dysfunction; 2) the phenomenon of cardiac surgery-related myocardial stunning; 3) possible ongoing acute ischemia (which must be treated, prior to or while supporting the heart with inotropes); 4) the improved ventricular function resulting from the restoration of blood flow to the chronically ischemic or hibernating myocardium following coronary artery bypass grafting (when performed).

When to use an inotrope. Even though in some institutions inotropes are routinely administered after weaning from CPB, a better rationale may be based on the following criteria: a) the expected need for inotropes, bearing in mind the above-mentioned preoperative and intraoperative criteria and the expected pathophysiology of the specific underlying pathology (for example, after valve replacement of an isolated severely stenotic aortic valve, inotropic support will rarely be required); b)

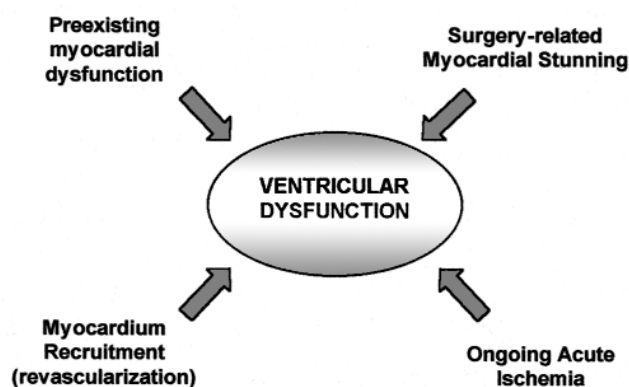


Figure 2. Factors determining the extent of postoperative ventricular dysfunction and potential troubles in weaning from cardiopulmonary bypass.

clinical evidence of depressed myocardial function, as guided by hemodynamic monitoring (measurement of heart rate, blood pressure, cardiac output, visual inspection of the heart, transesophageal echocardiographic inspection); c) empirical drug choice and titration, with careful hemodynamic monitoring. Prolonged, inappropriate or excessive treatment with inotropic medication may in fact augment the perioperative ischemic injury^{15,30} and adversely affect myocardial function and weaning from CPB; this is especially true when tachycardia, arrhythmias and oxygen consumption are enhanced.

The initiation of inotropic drugs before weaning from CPB is controversial and has not been thoroughly evaluated in large controlled clinical studies, but the consequences of a failed wean may be severe (ventricular distention, additional pump time, systemic hypotension/hypoperfusion, subsequent need for multiple inotropes or mechanical assistance, neurological sequelae, additional costs). Many authors therefore advocate early inotropic intervention, on the basis of the expected need, to provide the heart with the increase in contractility necessary to support the circulation and expedite weaning, with beneficial effects³¹⁻³³.

Choice of the inotrope. The ideal positive inotropic agent should enhance contractility (both right and left ventricular) without any significant increase in heart rate, preload, afterload, and myocardial oxygen consumption. It should also enhance the diastolic function, maintain the diastolic coronary perfusion pressure and thus an adequate myocardial blood flow³⁴. It finally should have rapid titration times and onset of action and a short half-life. But no ideal inotrope exists, and neither does an inotrope without some limitation in its use. The currently available inotropic drugs include beta-adrenergic agonists (dopamine, dobutamine, epinephrine, isoproterenol, norepinephrine, dopexamine), phosphodiesterase (PDE) inhibitors (amrinone, milrinone, enoximone), and the recently introduced calcium sensitizers (levosimendan). As known, the first two groups of drugs both act by increasing the intracellular cyclic adenosine monophosphate (cAMP) and calcium concentrations, while the third does not. Other pharmacological agents (vesnarinone, saterinone, pimobendan, forskolin) have in the past been tried without success. A detailed description of the pharmacology of inotropes goes beyond the aim of this review, but some of the properties of these drugs and some theoretical concepts of inotropic administration in the context of perioperative heart failure will be here discussed.

Catecholamines are the mainstay of current inotropic treatment and they exert a positive inotropic effect mainly by stimulation of the cardiac beta-receptors; they can be divided into more potent (epinephrine, isoproterenol, noradrenaline) and milder (dopamine, dopexamine, dobutamine). Dopamine and dopexamine do not act as direct beta-agonists, as they achieve part of their effect by releasing the myocardial norepinephrine stores or by preventing the re-uptake of norepinephrine.

The dose-dependent effects of *dopamine* (acting on the dopaminergic receptors) are not specific and are influenced by receptor regulation, intra- and interindividual variability and drug interactions; its alpha-mediated vasoconstrictor action (mainly at high doses) renders it more suitable when a combination of inotropic support and vasoconstriction is required. Initially the inotrope of choice after cardiac surgery, dopamine has now been shown to cause more tachycardia than epinephrine at comparable doses³⁵ and to determine higher filling pressures than dobutamine for similar hemodynamic indices³⁶. In addition to its dopaminergic action, *dopexamine* (synthetic analogue of dopamine) has a higher affinity for beta₂ than beta₁ receptors and may determine an increase in splanchnic blood flow and urinary output. In the management of patients after CPB, it was found to induce tachycardia³⁷ with an increase in cardiac index equivalent to that of dobutamine³⁸ and with vasodilation³⁹. As a result of its dopaminergic properties, dopexamine may be valuable in the patients with septic shock after CPB⁴⁰. *Dobutamine*, with a predominant beta₁ activity and a balanced peripheral beta₂ and alpha₁ activation, increases the cardiac output and reduces the diastolic filling pressures, with a mild dilating effect on the systemic vascular resistance. In paced cardiac surgery patients, dobutamine increases myocardial oxygen supply and coronary blood flow, unlike dopamine, which tends to worsen the oxygen supply-demand balance⁴¹: dobutamine seems to be therefore a more suitable inotrope in coronary artery disease. But, being the increases in heart rate a major determinant of myocardial oxygen consumption, these favorable effects could be lost when dobutamine induces tachycardia. After coronary artery surgery, dobutamine produces a less favorable heart rate response compared to equipotent doses of epinephrine⁴². Dobutamine also shows a greater inotropic effect on the right ventricular myocardium than dopamine⁴³. The development of tolerance (within 48-72 hours) in prolonged administration is one of the limits of its use⁴⁴.

With regard to *epinephrine*, traditional concerns have stressed an association with tachycardia, vasoconstriction and myocardial ischemia⁴⁵, but this appears not to be true at low doses, due to a prevalent stimulation of beta-adrenoreceptors (after cardiac surgery, epinephrine 0.01 to 0.03 µg/kg/min induces less tachycardia compared with dobutamine 2.5-5 µg/kg/min, for a similar hemodynamic improvement)⁴². Epinephrine is a potent inotrope for both the right and left ventricles. *Norepinephrine*, mainly through an alpha-adrenergic action but not devoid of beta-stimulating activity, may benefit patients in whom it is necessary to maintain an adequate perfusion pressure, such as in right ventricular dysfunction or excessive vasodilator states. *Isoproterenol* has potent chronotropic and arterial vasodilator (both systemic and pulmonary) effects, due to its beta₁ and beta₂ activity. Limited in use in most patients with coronary artery disease⁴⁶, it is the inotrope of choice in

acute bradyarrhythmias, atrioventricular blocks and orthotopic heart transplantation.

Comparative studies have not shown clinically significant differences among the various *PDE III inhibitors*: they all share a significant inotropic effect (not altered by previous beta-blocker therapy or beta-receptor downregulation), a pulmonary and systemic vasodilator action, fewer chronotropic effects than dobutamine⁴⁷, with an apparent favorable effect on myocardial oxygen consumption⁴⁸. The use of PDE inhibitors has been reported to be beneficial in the treatment of right heart failure⁴⁹, and in determining vasodilation of arterial coronary bypass grafts and native vessels^{50,51}. Even though by increasing the intracellular cAMP concentration all inotropic agents also improve diastolic function, PDE inhibitors seem to exert a greater lusitropic effect compared to epinephrine⁵², perhaps because they also cause a significant afterload reduction. Compared to dobutamine, PDE inhibitors also seem to have a lesser proarrhythmic effect⁵³. Potential drawbacks include a possible excessive vasodilator effect (associated with bolus administration) and the long duration of action.

Levosimendan, a novel calcium-sensitizing agent with inodilator properties, works with a dual mechanism of action: it increases contractility without increasing oxygen consumption through calcium sensitization, and it produces venous, arterial, and coronary vasodilation through smooth muscle K_{ATP} channels⁵⁴. It may also exert a beneficial effect on diastolic function through the calcium dependency of its troponin C sensitization^{55,56}, and through its anti-stunning effect⁵⁴. Though limited, the presently available perioperative experience with levosimendan after coronary bypass surgery is encouraging, showing a hemodynamic benefit comparable to that of dobutamine or PDE inhibitors, without a significant increase in oxygen consumption^{57,58}.

Indications in specific settings. As described above, the problem of postoperative myocardial dysfunction is quite a complex matter, and a clear understanding of its principles and features in different clinical settings is important when deciding which inotropic drug(s) is/are to be used. Different types of clinical scenarios of heart failure can be encountered during weaning from CPB (Table II).

During coronary artery bypass graft surgery, inotropes may be needed in case of preexisting ventricular dysfunction or in case of unsuccessful revascularization if the intra-aortic balloon pump alone is not enough (along with the pharmacological treatment of ischemia). In most cases, myocardial recruitment by revascularization will otherwise determine no or only mild inotrope requirement in this setting⁵⁹. In the emergency revascularization of acute myocardial infarction, dobutamine and PDE inhibitors may be the most beneficial inotropes, as they may better influence the oxygen delivery/consumption balance^{41,53}.

Table II. Common clinical settings of heart failure encountered in cardiac surgery, mainly during weaning from cardiopulmonary bypass.

Previous reduced EF after CABG, or unsuccessful revascularization
Inotropic support during off-pump CABG
Left heart failure in surgical treatment of dilated cardiomyopathy (mitral valve surgery, high-risk conventional revascularization, dynamic cardiomyoplasty, Batista procedure)
Left ventricular dysfunction after ventricular aneurysm resection
Ventricular dysfunction after valvular surgery
Ventricular dysfunction after ascending aorta or aortic arch surgery
Right or biventricular failure after heart transplantation
Right heart failure after LVAD implantation
Right heart failure in lung transplantation
Right heart failure in pulmonary thromboendarterectomy
Heart failure in emergency cardiac surgery (acute valvular disease, ascending aorta dissection, acute MI, cardiac tamponade)
Ventricular dysfunction in congenital heart disease correction

CABG = coronary artery bypass graft; EF = ejection fraction; LVAD = left ventricular assist device; MI = myocardial infarction.

Cardiac output during off-pump coronary artery bypass graft surgery is reduced due to both right and left ventricular dysfunction⁶⁰, mainly when the heart is displaced out of the pericardium for grafting the circumflex artery. When the Trendelenburg position, fluid infusion and a vasoconstrictor do not suffice to restore acceptable hemodynamics, the use of inotropes with no or only a mild vasodilator action (dopamine, dobutamine) is required⁶¹.

In patients with preexisting chronic heart failure (especially those presenting for the surgical treatment of a dilated cardiomyopathy: mitral valve surgery, revascularization, remodeling surgery), the myocardium presents unique features attributable to chronic catecholamine hyperstimulation: β_1 receptor downregulation with a reduction in receptor density (proportional to the severity of systolic dysfunction), a shift in proportion of β_1 vs β_2 receptors (from the normal 80:20 to 60:40)^{62,63}, and low intracellular levels of cAMP⁶⁴. Furthermore, acute changes in beta-adrenergic receptor function can also occur during cardiac surgery^{65,66}. Catecholamine stimulation alone is thus submaximal, reaching a *plateau* effect on adenylyl cyclase⁶², and even the response to PDE inhibitors alone could be blunted (by a reduced intracellular cAMP pool): combination therapy (i.e. a PDE inhibitor administered along with a beta-adrenergic inotrope, dobutamine or epinephrine) may therefore be the treatment of choice in these patients, exploiting a synergistic action and minimizing the side effects of the single drugs (PDE inhibitors may cause excessive vasodilation, counteracted by catecholamine alpha-stimulation, and vice versa). As a chronically dysfunctional myocardium is also characterized by the depletion of the myocardial stores of norepinephrine⁶⁷, indirect beta-adrenergic agents (dopamine, dopexamine) would be inadequate.

The same principles apply in case of extreme ventricular dysfunction: severe myocardial stunning (due to

surgical complications determining long aortic cross-clamping times or, in emergency surgery, to pre-CPB ischemia inducing extensive reperfusion injury) may require important inotropic support with combination therapy.

When choosing an inotropic agent, the problem of diastolic dysfunction must be taken into account. When marked ventricular hypertrophy is present (severe aortic stenosis, hypertrophic obstructive cardiomyopathy) and is complicated by the onset of edema subsequent to inadequate myocardial protection, the use of beta-adrenergic agents may worsen the diastolic function with a decrease in cardiac output. No inotropes at all (or inotropes with a better effect on ventricular relaxation, such as PDE inhibitors, if systolic dysfunction coexists) should be used. The maintenance of adequate preload and perfusion pressures is also essential⁶⁸. For similar reasons, after the resection of a ventricular aneurysm (which may greatly reduce the compliance of the left ventricular chamber), a better therapeutic choice to enhance the diastolic function would be to administer PDE inhibitors. During partial left ventriculectomy surgery (Batista procedure) both problems of severe systolic and diastolic dysfunction coexist, frequently requiring a combination of inotropes, vasoconstrictors, and mechanical support⁶⁹.

With regard to valvular surgery, the ventricular response to successful surgery varies according to the various forms of valve disease⁷⁰. After aortic valve replacement for moderately severe aortic stenosis, the afterload is markedly reduced, but left ventricular hypertrophy and diastolic dysfunction persist: inotropic support is rarely needed, unless inadequate myocardial protection or prolonged aortic cross-clamping complicate the procedure. All other left-sided valvular diseases may bare a certain degree of systolic dysfunction induced by the long-standing abnormal loading conditions of the ventricle. After successful aortic valve replacement for chronic aortic insufficiency, ventricular dilation and dysfunction persist, requiring adequate preload and inotropes. With mitral stenosis, preoperative atrial fibrillation and pulmonary hypertension may limit the potential for the recovery of full function, whereas with chronic mitral regurgitation, surgical correction acutely increases the afterload in a dilated heart: in both cases, treatment with inotropes is warranted. Acute aortic and mitral regurgitation both pose a great risk of severe ventricular dysfunction after surgical correction and require aggressive inotropic support even preoperatively. Finally, tricuspid regurgitation is almost always associated with right ventricular dysfunction (both for pulmonary hypertension and primary ventricular failure), and hence inotropes are beneficial even in this context.

Although the carefully selected and well preserved transplanted heart has a normal contractile function, it lacks the normal autonomic control of chronotropy and inotropy because of the interruption of the autonomic

innervation. Routine inotropic support after orthotopic cardiac transplantation thus includes isoproterenol (to increase the automaticity, inotropism and pulmonary vasodilation) and dopamine (to add further support whilst maintaining the systemic perfusion pressures)⁷¹. The most frequent problems derive from: the sudden exposure of the unconditioned donor right ventricle to an excessive afterload stress imposed by the elevated pulmonary vascular resistance, with right heart failure⁷²; the prolonged graft ischemia or inadequate myocardial protection (excessive pre-harvesting catecholamine exposure), with possible biventricular failure. Both these situations require aggressive inotropic support and the management of right ventricular failure⁷¹.

Right ventricular dysfunction may occur in different perioperative settings (heart transplantation⁷², lung transplantation⁷³, pulmonary thromboendarterectomy⁷⁴, left ventricular assist device implantation⁷⁵, inadequate myocardial protection), and the pharmacological approach to this condition deserves particular mention. A high right ventricular filling pressure (traditional volume loading in right ventricular infarction treatment) restores normal hemodynamics only if the pulmonary vascular resistance, right ventricular contractility, and interventricular septum geometry are normal³⁴. Successful management must thus include: a reduction in right ventricular afterload (pulmonary vasodilators, better if selective, with a non-systemic action)⁷⁶; the augmentation of the contractile strength (inotropes effective on the right ventricular myocardium: dobutamine, isoproterenol, epinephrine, PDE inhibitors) with the aim of reducing the right ventricular size and improve left ventricular filling; the maintenance of the aortic blood pressure, especially if high fixed pulmonary resistance is present (vasoconstrictors may augment the right ventricular performance when the coronary perfusion pressure is reduced by the increased right ventricular end-diastolic pressure)^{77,78}.

After heart transplantation, right heart failure may develop immediately or during the early postoperative period⁷¹, especially in patients with significant preoperative pulmonary hypertension. In lung transplantation, several critical stages place the usually hypertrophied right ventricle at a high risk of failure⁷⁹: the induction of anesthesia (hypotension), the initiation of positive-pressure ventilation (increase in right ventricular afterload, hyperinflation with circulatory collapse), the institution of one lung ventilation (severe hypoxia), the clamping of the pulmonary artery (sudden increase in afterload), the unclamping of the pulmonary artery (profound hypotension). Norepinephrine, in addition to low-dose epinephrine (or dobutamine) and cautious fluid loading, is often invaluable in this difficult setting⁷³. After thromboendarterectomy, inotropes may be necessary in case of significant preoperative right ventricular dysfunction or if surgery is not successful in re-establishing the patency of the pulmonary vessels, taking care to avoid a supranormal cardiac output (responsible for

overflow to the reperfused areas and causing reperfusion pulmonary edema)⁷⁴. Norepinephrine may also be helpful. Finally, after left ventricular assist device implantation varying degrees of right ventricular failure usually occur and these patients are invariably in a state of vasodilator shock; both inotropes (dobutamine and amrinone) and vasoconstrictors (norepinephrine) are beneficial. Severe refractory vasodilation may require the addition of epinephrine⁷⁵.

Inotropic drugs in the intensive care setting

Besides the need for inotropic drugs in the postoperative care of the cardiac surgical patient, which follows the above-mentioned principles, other intensive care unit (other than coronary) clinical scenarios may require the use of intravenous inotropes (Table III). A brief review of these clinical settings is discussed below.

Patients with chronic heart failure may be admitted to the intensive care unit when the acute exacerbation is so severe as to warrant mechanical ventilation. In this group of patients, if refractory to standard first-line therapy with diuretics and vasodilators, short-term inotropic treatment (dobutamine, PDE inhibitors) is commonly performed with benefit^{80,81}.

If adequately resuscitated using fluids, patients with septic shock develop a hyperdynamic circulatory state (low systemic resistance, high cardiac output). Nevertheless, sepsis-related myocardial dysfunction is one manifestation of this complex cardiovascular derangement, and the metabolic demand can exceed myocardial performance: even though in case of sepsis, cardiogenic shock with a low cardiac output is rare, normotensive sepsis and septic shock are associated with a reduced post-resuscitation left ventricular ejection fraction⁸²⁻⁸⁴, acute ventricular dilation^{82,84} and a depressed response to volume resuscitation (flattening of the Frank-Starling relationship)^{85,86}, which typically peak within the first few days and resolve by 7 to 10 days in survivors⁸². Besides a decreased contractility, myocardial compliance abnormalities may also have a sub-

stantial role in this form of reversible myocardial depression^{84,86}. Right ventricular dysfunction (with a reduction in ejection fraction and dilation) parallels left ventricular failure, independently of the increase in right ventricular afterload^{82,87-89}. Moreover, the cardiovascular profiles of non-survivors are characterized by an inability to dilate their ventricles, or by persistence of the ventricular dysfunction and of the hyperdynamic state^{89,90}. It is thus now understood that acute reversible ventricular dilation may represent an adaptive response to septic stress⁹¹. Recent studies have shown that patients with sepsis and septic shock can exhibit resistance to the normal vasopressor and inotropic action of catecholamines⁹², and that a preserved response to dobutamine stimulation can be used to differentiate survivors and non-survivors^{93,94}. Part of the complex pathogenesis of this peculiar form of myocardial dysfunction is probably attributable to adrenergic desensitization⁹², in addition to, or as a consequence of, the effects of humoral and intracellular mediators, such as cytokines and nitric oxide⁹⁵.

Being the main aim of the hemodynamic management of septic shock the re-establishment of an adequate systemic perfusion and oxygenation, the mainstay of treatment includes the optimization of the preload and the use of vasopressors and inotropes⁹⁶. Different inotropic drugs are used to treat sepsis-induced cardiac dysfunction, mainly dobutamine. In a recent *in vitro* study, a greater effectiveness of amrinone over epinephrine has been observed⁹⁷, but the clinical use of inodilators in this setting may be limited by their potent systemic vasodilator effect⁹⁸. Calcium sensitization has been proposed as a new approach to increase myocardial contractility, and is still under investigation. Catecholamines with beta-mimetic effects are often also used to increase oxygen delivery: under conditions of an adequate volume replacement, dobutamine increases the cardiac output and oxygen delivery to a greater extent than dopamine⁹⁹. However, conflicting results emerge from different studies trying to demonstrate an improved survival with supranormal goal-directed therapy (targeted at a supranormal cardiac index)^{100,101}, and the question as to whether dobutamine or dopamine should be first used in the treatment of septic shock cannot yet be answered¹⁰².

Even though functional cardiac injuries can be frequently observed as a result of blunt trauma¹⁰³, patients with myocardial contusion/concussion requiring inotropic support are rare^{104,105}, unless previous chronic heart failure is present or complications of polytrauma ensue: the population of traumatized patients is often younger than the one with the highest prevalence of cardiac disease, and the non-surgical complications of cardiac trauma are usually mild.

Patients with severe chronic obstructive pulmonary disease, despite the presence of pulmonary hypertension, usually have a normal right ventricular contractility¹⁰⁶,

Table III. Clinical settings of heart failure encountered in (non coronary) intensive care units.

Postoperative care of cardiac surgery patients
Non-surgical causes of heart failure requiring mechanical ventilation: chronic heart failure with superimposing critical illness or precipitating factors, severe myocarditis
Septic shock patients with myocardial dysfunction
Myocardial contusion in thoracic trauma or polytrauma
Right ventricular dysfunction in mechanically ventilated patients with acute respiratory failure (severe chronic obstructive pulmonary disease, acute asthma)
Right ventricular dysfunction in acute respiratory distress syndrome patients
Cardiogenic shock in patients with severe pulmonary thromboembolism

and, even when admitted to the intensive care unit for acute respiratory failure requiring mechanical ventilation, rarely need to be treated with inotropes, unless other complicating factors intervene. In patients with the acute respiratory distress syndrome a chain of events may lead to right ventricular dysfunction: severe hypoxia with reactive pulmonary vasoconstriction can determine pulmonary hypertension; furthermore, mechanical ventilation with high pressure regimens determines both an increase in the right ventricular afterload and a reduction in the right ventricular preload. This creates extremely unfavorable conditions for the right ventricle, posing a great risk of right ventricular ischemia and failure. The failing right ventricle may also interfere with the correct left ventricular functioning due to the interventricular dependency¹⁰⁷. Part of the complex therapeutic approach to the acute respiratory distress syndrome includes fluid restriction, so as not to worsen the lesional edema. Hence, norepinephrine is commonly used in order to maintain the perfusion pressures; dobutamine may also be used to improve the contractility of the right ventricle and maintain an adequate cardiac output¹⁰⁸.

Finally, acute massive pulmonary thromboembolism determines a severe form of right ventricular failure which may necessitate aggressive inotropic support (dopamine, dobutamine, epinephrine), if fluid infusion therapy and vasoconstrictors (norepinephrine) alone cannot maintain hemodynamic stability¹⁰⁹.

References

- Mangano DT. Perioperative cardiac morbidity. *Anesthesiology* 1990; 72: 153-84.
- Salomon NW, Page US, Bigelow JC, Krause AH, Okies JE, Metzendorff MT. Coronary artery bypass grafting in elderly patients: comparative results in a consecutive series of 469 patients older than 75 years. *J Thorac Cardiovasc Surg* 1991; 101: 209-18.
- Tuman KJ, McCarthy RJ, Najafi H, Ivanovich AD. Differential effects of advanced age on neurologic and cardiac risks of coronary artery operations. *J Thorac Cardiovasc Surg* 1992; 104: 1510-7.
- National Health and Nutrition Examination Survey III, 1988-1994. Hyattsville, MD: Centers of Health Statistics and the American Heart Association.
- Krishnagopalan S, Kumar A, Parrillo JE, Kumar A. Myocardial dysfunction in the patient with sepsis. *Curr Opin Crit Care* 2002; 8: 376-88.
- Lewis KP. The use of amrinone in noncardiac surgery. *J Cardiothorac Anesth* 1990; 6: S34-S40.
- Breisblatt WM, Stein KL, Wolfe CJ, et al. Acute myocardial dysfunction and recovery: a common occurrence after coronary bypass surgery. *J Am Coll Cardiol* 1990; 15: 1261-9.
- Gray R, Maddahi J, Berman D, et al. Scintigraphic and hemodynamic demonstration of transient left ventricular dysfunction immediately after uncomplicated coronary artery bypass grafting. *J Thorac Cardiovasc Surg* 1979; 77: 504-10.
- Reduto LA, Lawrie GM, Reid JW, et al. Sequential post-operative assessment of left ventricular performance with gated cardiac blood pool imaging following aortocoronary bypass surgery. *Am Heart J* 1981; 101: 59-66.
- Dubroff JM, Clark MB, Wong CY, Spotnitz AJ, Collins RH, Spotnitz HM. Left ventricular ejection fraction during cardiac surgery: a two-dimensional echocardiographic study. *Circulation* 1983; 68: 95-103.
- Gold JP, Roberts AJ, Hoover EL, Blank S, Gay WA Jr, Subramanian VA. Effects of prolonged aortic cross-clamping with potassium cardioplegia on myocardial contractility in man. *Surg Forum* 1979; 30: 252-4.
- Swanson DK, Myernowitz PD. Effect of reperfusion temperature and pressure on the functional and metabolic recovery of preserved hearts. *J Thorac Cardiovasc Surg* 1983; 86: 242-51.
- Casey LC. Role of cytokines in the pathogenesis of cardiopulmonary-induced multisystem organ failure. *Ann Thorac Surg* 1993; 56 (Suppl): S92-S96.
- Vinten-Johansen J, Johnston WE, Mills SA, et al. Reperfusion injury after temporary coronary occlusion. *J Thorac Cardiovasc Surg* 1988; 95: 960-8.
- Lazar HL, Buckberg GD, Foglia RP, Manganaro AJ, Maloney JV Jr. Detrimental effects of premature use of inotropic drugs to discontinue cardiopulmonary bypass. *J Thorac Cardiovasc Surg* 1981; 82: 18-25.
- Braunwald E, Kloner RA. The stunned myocardium: prolonged, postischemic ventricular dysfunction. *Circulation* 1982; 66: 1146-9.
- Bolli R, Hartley CJ, Rabinovitz RS. Clinical relevance of myocardial "stunning". *Cardiovasc Drugs Ther* 1991; 5: 877-90.
- Vinten-Johansen J, Nakanishi K. Postcardioplegia acute cardiac dysfunction and reperfusion injury. *J Cardiothorac Vasc Anesth* 1993; 7 (Suppl 2): S6-S18.
- Heydrickx GR, Baig H, Nellens P, Leusen I, Fishbein MC, Vatner SF. Depression of regional blood flow and wall thickening after brief coronary occlusions. *Am J Physiol* 1978; 234: H653-H659.
- Mangano DT. Biventricular function after myocardial revascularization in humans: deterioration and recovery patterns during the first 24 hours. *Anesthesiology* 1985; 62: 571-7.
- Ballantyne CM, Verani MS, Short HD, Hyatt C, Noon GP. Delayed recovery of severely "stunned" myocardium with the support of a left ventricular assist device after coronary artery bypass graft surgery. *J Am Coll Cardiol* 1987; 110: 710-2.
- Royster RL. Myocardial dysfunction following cardiopulmonary bypass: recovery patterns, predictors of inotropic need, theoretical concepts of inotropic administration. *J Cardiothorac Vasc Anesth* 1993; 7 (Suppl 2): S19-S25.
- Gorcsan J III, Gasior TA, Mandarino WA, Deneault LG, Hattler BG, Pinsky MR. Assessment of the immediate effects of cardiopulmonary bypass on left ventricular performance by on-line pressure-area relations. *Circulation* 1994; 89: 180-90.
- McKenney PA, Apstein CS, Mendes LA, et al. Increased left ventricular diastolic chamber stiffness immediately after coronary artery bypass surgery. *J Am Coll Cardiol* 1994; 24: 1189-94.
- Casthley PA, Shah C, Mekhjian H, et al. Left ventricular diastolic function after coronary artery bypass grafting: a correlative study with three different myocardial protection techniques. *J Thorac Cardiovasc Surg* 1997; 114: 254-60.
- Goenen M, Jacquemart JL, Galvez S, Baele P, Robert A, Ponlot R. Preoperative left ventricular dysfunction and operative risks in coronary bypass surgery. *Chest* 1987; 92: 804-6.
- Royster RL, Butterworth JF IV, Prough DS, et al. Preoperative and intraoperative predictors of inotropic support and long-term outcome in patients having coronary artery bypass grafting. *Anesth Analg* 1991; 72: 729-36.
- Rao V, Ivanov J, Weisel RD, Ikonomidis JS, Christakis GT, David TE. Predictors of low cardiac output syndrome

- after coronary artery bypass. *J Thorac Cardiovasc Surg* 1996; 112: 38-51.
29. Butterworth JF IV, Legault C, Royster RL, Hammon JW Jr. Factors that predict the use of positive inotropic drug support after cardiac valve surgery. *Anesth Analg* 1998; 86: 461-7.
 30. Mickleborough LL, Rebeyka I, Wilson GJ, Gray G, Desrosiers A. Comparison of left ventricular assist and intra-aortic balloon counterpulsation during early reperfusion after ischemic arrest of the heart. *J Thorac Cardiovasc Surg* 1987; 93: 597-608.
 31. Lewis KP. Early intervention of inotropic support in facilitating weaning from cardiopulmonary bypass: the New England Deaconess Hospital experience. *J Cardiothorac Vasc Anesth* 1993; 7 (Suppl 2): S40-S45.
 32. Hardy JF, Belisles S. Inotropic support of the heart that fails to successfully wean from cardiopulmonary bypass: the Montreal Heart Institute experience. *J Cardiothorac Vasc Anesth* 1993; 7 (Suppl 2): S33-S39.
 33. Kirklin JK. The postperfusion syndrome: inflammation and the damaging effects of cardiopulmonary bypass. In: Tinker JH, ed. *Cardiopulmonary bypass: current concepts and controversies*. Philadelphia, PA: WB Saunders, 1989: 131-46.
 34. Griffin MJ, Hines RL. Management of perioperative ventricular dysfunction. *J Cardiothorac Vasc Anesth* 2001; 15: 90-106.
 35. Steen PA, Tinker JJ, Pluth JR, Barnhrst DA, Tarhan S. Efficacy of dopamine, dobutamine, and epinephrine during emergence from cardiopulmonary bypass in man. *Circulation* 1978; 57: 378-84.
 36. DiSesa VJ, Gold JP, Shemin RJ, Collins JJ Jr, Cohn LH. Comparison of dopamine and dobutamine in patients requiring postoperative circulatory support. *Clin Cardiol* 1986; 9: 253-6.
 37. Santman FW. Prolonged infusion of varied doses of dopexamine hydrochloride for low cardiac output after cardiac surgery. *J Cardiothorac Vasc Anesth* 1992; 6: 568-72.
 38. MacGregor DA, Butterworth JF IV, Zaloga CP, Prielipp RC, James R, Royster RL. Hemodynamic and renal effects of dopexamine and dobutamine in patients with reduced cardiac output following coronary artery bypass grafting. *Chest* 1994; 106: 835-41.
 39. Hunter DN, Gray H, Mudaliar Y, Morgan C, Evans TW. The effects of dopexamine hydrochloride on cardiopulmonary hemodynamics following cardiopulmonary bypass surgery. *Int J Cardiol* 1989; 23: 365-71.
 40. Friedel N, Wenzel R, Matheis G, et al. Haemodynamic effects of different doses of dopexamine hydrochloride in low cardiac output states following cardiac surgery. *Eur Heart J* 1992; 13: 1271-6.
 41. Fowler MB, Alderman EL, Oesterle SN, et al. Dobutamine and dopamine after cardiac surgery: greater augmentation of myocardial blood flow with dobutamine. *Circulation* 1984; 70 (Part 1): I103-I111.
 42. Butterworth JF, Prielipp RC, Royster RL, et al. Dobutamine increases heart rate more than epinephrine in patients recovering from aortocoronary bypass surgery. *J Cardiothorac Vasc Anesth* 1992; 6: 535-41.
 43. Vincent JL, Reuse C, Kahn RJ. Effects on right ventricular function of a change from dopamine to dobutamine in critically ill patients. *Crit Care Med* 1988; 16: 659-62.
 44. Unverferth DV, Blanford M, Kates RE, Leier CV. Tolerance to dobutamine after a 72 hour continuous infusion. *Am J Med* 1980; 69: 262-6.
 45. Schechter E, Wilson MF, Kong YS. Physiologic responses to epinephrine infusion: the basis for a new stress test for coronary artery disease. *Am Heart J* 1983; 105: 554-60.
 46. Mueller H, Ayres SM, Gregory JJ, Giannelli S Jr, Grace WJ. Hemodynamics, coronary blood flow, and myocardial metabolism in coronary shock: response to l-norepinephrine and isoproterenol. *J Clin Invest* 1970; 49: 1885-902.
 47. Borow KW, Neumann A, Lang RM. Milrinone versus dobutamine: contribution of altered myocardial mechanics and augmented inotropic state to improved left ventricular performance. *Circulation* 1986; 73 (Part 2): III153-III161.
 48. Baim DS. Effect of phosphodiesterase inhibition on myocardial oxygen consumption and coronary blood flow. *Am J Cardiol* 1989; 63: 23A-26A.
 49. Hess W, Arnold B, Veit S. The haemodynamic effects of amrinone in patients with mitral stenosis and pulmonary hypertension. *Eur Heart J* 1986; 7: 800-7.
 50. Liu JJ, Doolan LA, Xie B, Chen JR, Buxton BF. Direct vasodilator effect of milrinone, an inotropic drug, on arterial coronary bypass grafts. *J Thorac Cardiovasc Surg* 1997; 113: 108-13.
 51. Chatterjee K. Phosphodiesterase inhibitors: alterations in systemic and coronary hemodynamics. *Basic Res Cardiol* 1989; 84 (Suppl 1): S213-S224.
 52. Lobato EB, Gravenstein N, Martin TD. Milrinone, not epinephrine, improves left ventricular compliance after cardiopulmonary bypass. *J Cardiothorac Vasc Anesth* 2000; 14: 374-7.
 53. Caldicott LD, Hawley K, Heppell R, Woodmansey PA, Channer KS. Intravenous enoximone or dobutamine for severe heart failure after acute myocardial infarction: a randomized double-blind trial. *Eur Heart J* 1993; 14: 696-700.
 54. Figgitt DP, Gillies PS, Goa KL. Levosimendan. *Drugs* 2001; 61: 613-29.
 55. Pagel PS, Harkin CP, Hetttrick DA, Warltier DC. Levosimendan (OR-1259), a myofilament calcium sensitizer, enhances myocardial contractility but does not alter isovolumic relaxation in conscious and anesthetized dogs. *Anesthesiology* 1994; 81: 974-87.
 56. Hasenfuss G, Pieske B, Castell M, Kretschmann B, Maier LS, Just H. Influence of the novel inotropic agent levosimendan on isometric tension and calcium cycling in failing human myocardium. *Circulation* 1998; 98: 2141-7.
 57. Lilleberg J, Nieminen MS, Akkila J, et al. Effect of a new calcium sensitizer, levosimendan, on hemodynamics, coronary blood flow and myocardial substrate utilization early after coronary artery bypass grafting. *Eur Heart J* 1998; 19: 660-8.
 58. Nijhiawan N, Nicolosi AC, Montgomery MW, Aggarwal A, Pagel PS, Warltier DC. Levosimendan enhances cardiac performance after cardiopulmonary bypass: a prospective, randomized placebo-controlled trial. *J Cardiovasc Pharmacol* 1999; 34: 219-28.
 59. O'Connor JP, Ramsay JG, Wynands JE, Kaplan JA. Anesthesia for myocardial revascularization. In: Kaplan JA, ed. *Cardiac anesthesia*. Philadelphia, PA: WB Saunders, 1993: 587-628.
 60. Couture P, Denault A, Limoges P, Sheridan P, Babin D, Cartier R. Mechanisms of hemodynamic changes during off-pump coronary artery bypass surgery. *Can J Anaesth* 2002; 49: 835-49.
 61. Heames RM, Gill RS, Ohri SK, Hett DA. Off-pump coronary artery surgery. *Anaesthesia* 2002; 57: 676-85.
 62. Bristow MR, Ginsburg R, Minobe W, et al. Decreased catecholamine sensitivity and beta-adrenergic-receptor density in failing human hearts. *N Engl J Med* 1982; 307: 205-11.
 63. Bristow MR, Hershberger RE, Port JD, et al. Beta-adrenergic pathways in nonfailing and failing human ventricular myocardium. *Circulation* 1990; 82 (Suppl): I12-I25.
 64. Feldman MD, Copelas L, Gwathmey JK, et al. Deficient production of cyclic AMP: pharmacologic evidence of an important cause of contractile dysfunction in patients with end-stage heart failure. *Circulation* 1987; 75: 331-9.

65. Shwinn DA, Leone BJ, Spahn DR, et al. Desensitization of myocardial beta-adrenergic receptors during cardiopulmonary bypass. Evidence for early uncoupling and late downregulation. *Circulation* 1991; 84: 2559-67.
66. Booth JV, Landolfo KP, Chesnut LC, et al. Acute depression of myocardial β -adrenergic receptor signaling during cardiopulmonary bypass: impairment of the adenyl cyclase moiety. Duke Heart Center Perioperative Desensitization Group. *Anesthesiology* 1998; 98: 602-11.
67. Rutenberg HL, Spann JF Jr. Alterations of cardiac sympathetic neurotransmitter activity in congestive heart failure. *Am J Cardiol* 1973; 32: 472-80.
68. Troianos CA. Anesthesia for the surgical management of left ventricular outflow tract obstruction. In: This DM, ed. *Textbook of cardiothoracic anesthesiology*. New York, NY: McGraw-Hill, 2001: 644-56.
69. Cheng D, Vegas A. Anesthesia for the surgical management of ischemic heart disease. In: This DM, ed. *Textbook of cardiothoracic anesthesiology*. New York, NY: McGraw-Hill, 2001: 566-9.
70. De Villiers PA, Starr NJ. Anesthesia for the surgical management of valvular heart disease. In: This DM, ed. *Textbook of cardiothoracic anesthesiology*. New York, NY: McGraw-Hill, 2001: 589-629.
71. Dickstein ML. Anesthesia for heart transplantation. *Semin Cardiothorac Vasc Anesth* 1998; 2: 131-9.
72. Addonizio LJ, Gersony WM, Robbins RC, et al. Elevated pulmonary vascular resistance and cardiac transplantation. *Circulation* 1987; 76 (Part 2): V52-V55.
73. Myles PS. Aspects of anesthesia for lung transplantation. *Semin Cardiothorac Vasc Anesth* 1998; 2: 140-54.
74. Mares P, Gilbert TB, Tschenko EM, et al. Pulmonary artery thromboendarterectomy: a comparison of two different postoperative treatment strategies. *Anesth Analg* 2000; 90: 267-73.
75. Mets B. Anesthesia for left ventricular assist device placement. *J Cardiothorac Vasc Anesth* 2000; 14: 316-6.
76. Dell'Italia LJ, Starling MR, Blumhardt R, Lasher JC, O'Rourke RA. Comparative effects of volume loading, dobutamine, and nitroprusside in patients with predominant right ventricular infarction. *Circulation* 1985; 72: 1327-35.
77. Ghignone M, Girling L, Prewitt RM. Volume expansion versus norepinephrine in treatment of a low cardiac output complicating an acute increase in right ventricular afterload in dogs. *Anesthesiology* 1984; 60: 132-5.
78. Chow E, Farrar DJ. Effects of left ventricular pressure reductions on right ventricular systolic performance. *Am J Physiol* 1989; 257: H1878-H1885.
79. Bracken CA, Girkowsky MA, Naples JJ. Lung transplantation: historical perspective, current concepts, and anesthetic considerations. *J Cardiothorac Vasc Anesth* 1997; 11: 220-41.
80. Opasich C, Russo A, Mingrone M, Zambelli M, Tavazzi L. Intravenous inotropic agents in the intensive therapy unit: do they really make a difference? *Eur J Heart Fail* 2000; 2: 7-11.
81. The Task Force of the Working Group on Heart Failure of the European Society of Cardiology. The treatment of heart failure. *Eur Heart J* 1997; 18: 736-53.
82. Parker MM, Shelhamer JH, Bacharach SL, et al. Profound but reversible myocardial depression in patients with septic shock. *Ann Intern Med* 1984; 100: 483-90.
83. Ellrodt AG, Riedinger MS, Kimchi A, et al. Left ventricular performance in septic shock: reversible segmental and global abnormalities. *Am Heart J* 1985; 110: 402-9.
84. Poelaert J, Declercq C, Vogelaers D, Colardyn F, Visser CA. Left ventricular systolic and diastolic function in septic shock. *Intensive Care Med* 1997; 23: 553-60.
85. Weisel RD, Vito L, Dennis RC, Valeri CR, Hechtman HB. Myocardial depression during sepsis. *Am J Surg* 1977; 133: 512-21.
86. Ognibene FP, Parker MM, Natanson C, Shelhamer JH, Parrillo JE. Depressed left ventricular performance: response to volume infusion in patients with sepsis and septic shock. *Chest* 1988; 93: 903-10.
87. Sibbald WJ, Paterson NA, Holliday RL, Anderson RA, Lobb TR, Duff JH. Pulmonary hypertension in sepsis: measurements by the pulmonary arterial diastolic-pulmonary wedge pressure gradient and the influence of passive and active factors. *Chest* 1978; 73: 583-91.
88. Schneider AJ, Teule GJ, Groeneveld AB, Nauta J, Heidendal GA, Thijs LG. Biventricular performance during volume loading in patients with early septic shock, with emphasis on the right ventricle: a combined hemodynamic and radionuclide study. *Am Heart J* 1988; 116 (Part 1): 103-12.
89. Parker MM, McCarthy KE, Ognibene FP, Parrillo JE. Right ventricular dysfunction and dilatation, similar to left ventricular changes, characterize the cardiac depression of septic shock in humans. *Chest* 1990; 97: 126-31.
90. Parrillo JE, Parker MM, Natanson C, et al. Septic shock in humans: advances in understanding of pathogenesis, cardiovascular dysfunction, and therapy. *Ann Intern Med* 1990; 113: 227-42.
91. Kumar A, Haery C, Parrillo JE. Myocardial dysfunction in septic shock: Part I. Clinical manifestation of cardiovascular dysfunction. *J Cardiothorac Vasc Anesth* 2001; 15: 364-76.
92. Silverman HJ, Penaranda R, Orens JB, Lee NH. Impaired beta-adrenergic receptor stimulation of cyclic adenosine monophosphate in human septic shock: association with myocardial hyporesponsiveness to catecholamines. *Crit Care Med* 1993; 21: 31-9.
93. Vallet B, Chopin C, Curtis SE, et al. Prognostic value of the dobutamine test in patients with sepsis syndrome and normal lactate values: a prospective, multicenter study. *Crit Care Med* 1993; 21: 1868-75.
94. Rhodes A, Lamb FJ, Malagon I, Newman PJ, Grounds RM, Bennett ED. A prospective study of the use of a dobutamine stress test to identify outcome in patients with sepsis, severe sepsis, or septic shock. *Crit Care Med* 1999; 27: 2361-6.
95. Kumar A, Krieger A, Symeoneides S, Kumar A, Parrillo JE. Myocardial dysfunction in septic shock: Part II. Role of cytokines and nitric oxide. *J Cardiothorac Vasc Anesth* 2001; 15: 485-511.
96. Jindal N, Hollenberg SM, Dellinger RP. Pharmacologic issues in the management of septic shock. *Crit Care Clin* 2000; 16: 233-49.
97. Kumar A, Kosuri R, Kandula P, Dimou C, Allen J, Parrillo JE. Effects of epinephrine and amrinone on contractility and cyclic adenosine monophosphate generation of tumor necrosis factor- α -exposed cardiac myocytes. *Crit Care Med* 1999; 27: 286-92.
98. Carpati CM, Astiz ME, Rackow EC. Mechanisms and management of myocardial dysfunction in septic shock. *Crit Care Med* 1999; 27: 231-2.
99. Vincent JL, Van de Linden P, Domb M, Bleic S, Azimi G, Bernard A. Dopamine compared with dobutamine in experimental septic shock: relevance to fluid administration. *Anesth Analg* 1987; 66: 565-71.
100. Shoemaker WC, Appel PL, Kram HB, Waxman K, Lee TS. Prospective trial of supranormal values of survivors as therapeutic goals in high-risk surgical patients. *Chest* 1988; 94: 1176-86.
101. Gattinoni L, Brazzi L, Pelosi P, et al. A trial of goal-oriented hemodynamic therapy in critically ill patients. *SvO₂ Collaborative Group*. *N Engl J Med* 1995; 333: 1025-32.
102. Meier-Hellmann A, Reinhart K. Effects of catecholamines on regional perfusion and oxygenation in critically ill

- patients. *Acta Anaesthesiol Scand Suppl* 1995; 107: 239-48.
103. Lindstaedt M, Germing A, Lawo T, et al. Acute and long-term clinical significance of myocardial contusion following blunt thoracic trauma: results of a prospective study. *J Trauma* 2002; 52: 479-85.
104. Christensen MA, Sutton KR. Myocardial contusion: new concepts in diagnosis and management. *Am J Crit Care* 1993; 2: 28-34.
105. Krasna MJ, Flancbaum L. Blunt cardiac trauma: clinical manifestations and management. *Semin Thorac Cardiovasc Surg* 1992; 4: 195-202.
106. Biernacki W, Flenley DC, Muir AL, MacNee W. Pulmonary hypertension and right ventricular function in patients with COPD. *Chest* 1988; 96: 1169-75.
107. McNeil K, Dunning J, Morrell NW. The pulmonary physician in critical care. 13: The pulmonary circulation and right ventricular failure in the ITU. *Thorax* 2003; 58: 157-62.
108. Conrad SA, Bidani A. Management of the acute respiratory distress syndrome. *Chest Surg Clin N Am* 2002; 12: 325-54.
109. Meyer G. Treatment of severe pulmonary embolism. *Rev Prat* 1996; 46: 1240-3.