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의학 석사학위 논문

Sex-related differences in effect-site concentration of remifentanyl for preventing anesthetic emergence cough in elderly patients

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의학과

정윤용

Sex-related differences in effect-site concentration of remifentanyl for preventing anesthetic emergence cough in elderly patients

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이 논문을 의학 석사학위 논문으로 제출함.

2017 년 8 월

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Abstract

Background: Cough on anesthetic emergence should be prevented considering its dangerous complications. Target-controlled infusion (TCI) of remifentanyl can reduce emergence cough effectively, and sex-related differences in effect-site concentrations (Ce) of remifentanyl has been evaluated in young patients. In this study, we determined the Ce of remifentanyl for preventing emergence cough following extubation in male and female elderly patients and evaluated the sex-related difference.

Methods: Twenty-three male and 22 female elderly patients aged between 60 and 75 years were enrolled. Anesthesia was maintained with sevoflurane and remifentanyl TCI. The Ce of remifentanyl for preventing emergence cough was determined for each sex using isotonic regression method with a bootstrapping approach, following Dixon's up-and-down method.

Results: The Ce of remifentanyl for preventing emergence cough in 50% (EC₅₀) and 95% (EC₉₅) of the population were significantly lower in females than in males. Isotonic regression revealed the EC₅₀ (83% CI) of remifentanyl was 1.67 (1.55–1.83) ng/mL in females and 2.60 (2.29–2.91) ng/mL in males. The EC₉₅ (95 % CI) of remifentanyl was 2.30 (2.02–2.62) ng/mL in females and 3.41 (3.27–3.58) ng/mL in males. Dixon's up-and-down method indicated that the mean EC₅₀ in females was lower than in males (1.23 ± 0.21 ng/mL vs. 2.43 ± 0.21 ng/mL, $P < 0.001$).

Conclusions: The remifentanyl requirement for preventing emergence cough was lower in female than in male elderly patients, indicative of sex-related differences in Ce of remifentanyl. Sex should be considered when using remifentanyl TCI for preventing emergence cough in elderly patients.

Key words : TCI, remifentanyl, effect-site concentration, sex differences

목 차

Abstract.....	i
I. Introduction.....	1
II. Methods.....	3
III. Statistics.....	6
IV. Results.....	8
V. Discussion.....	14
References.....	17
국문요약.....	22

그림 목 차

Figure 1. Consort diagram.....	8
Figure 2. Assessment of success or failure at preventing emergence cough following extubation	10
Figure 3. Pooled-adjacent-violators algorithm response rates in females and males	11
Figure 4. The mean arterial pressure and heart rate during emergence of anesthesia and tracheal extubation.....	13

표 목 차

Table 1. Patients characteristics and operation details.....	8
Table 2. Effect-site concentration of remifentanyl for preventing emergence cough following extubation.....	11
Table 3. Emergence and recovery profiles.....	12

I. Introduction

Coughing on emergence from general anesthesia is common,¹ particularly when an endotracheal tube is utilized. Coughing at extubation may result in serious complications including laryngospasm, negative-pressure pulmonary edema, arterial hypertension, arrhythmia, bleeding, and wound disruption. Based on ASA' s recommendation of preformulated strategy for extubation by the anesthesiologist,² a variety of techniques have been tried to reduce emergence cough including opioids, lidocaine, dexmedetomidine, and deep extubation.³⁻⁶ These may be beneficial, but can delay emergence.

Remifentanyl is a potent ultrashort-acting opioid,⁷ with rapid onset and offset of drug effect. Moreover, it is affected minimally by extremes of age or renal or hepatic dysfunction. Remifentanyl allows rapid anesthetic emergence even after a prolonged infusion, and decreases the at-risk time during extubation. In addition, cough suppression of remifentanyl enables smooth extubation with reduced complications. Low-dose infusion than bolus dose of remifentanyl was determined to decrease the emergence cough,^{8,9} hence, target-controlled infusion (TCI) has been used to customize infusion rate for individual patients, which maintains a desired target concentration by using pharmacokinetic model.¹⁰ To date, several studies have examined the optimal effect-site concentration (Ce) of remifentanyl for preventing emergence cough following extubation.¹¹⁻¹⁹

Human studies have indicated that opioid has quantitative and qualitative differences in effect in male and female patients.²⁰⁻²³ Nevertheless, most studies regarding Ce of remifentanyl for preventing emergence cough have neglected sex-related difference, except for one study.¹⁸ Lee et al. reported the occurrence of sex-related differences in the Ce of remifentanyl for suppressing emergence cough among young patients aged 20-46 years.¹⁸ However, the elderly patient population shows a rapid rise, with 4 times higher surgery rates than young patients.²⁴ High comorbidities of elderly patients may lead to

detrimental hemodynamic changes on emergence cough, despite age-related decline of cough reflex.²⁵ In addition, elderly patients have different opioid sensitivity, as compared to young patients.^{23,26} Thus, there is a need to determine the Ce of remifentanil for smooth extubation in each sex of elderly patients.

The purpose of this study was to investigate the Ce of remifentanil for preventing emergence cough following extubation during general anesthesia among elderly patients and to evaluate possible sex-based differences.



II. Methods

This study was approved by Ajou University Hospital Institutional Review Board (protocol number: AJIRB-MED-CT4-15-55, 16th April 2015) and was registered at <http://cris.nih.go.kr> (registration number: KCT0001910). All data were set and collected in Ajou University School of Medicine. Twenty-three male and 22 female geriatric patients aged between 60 and 75 years with an American Society of Anesthesiologists (ASA) physical status I-II who underwent general anesthesia for laparoscopic cholecystectomy were included. Patients were excluded if any of the following criteria were present: Mallampati class 3 or 4, history of difficult intubation or respiratory disease, upper respiratory infection in previous 2 weeks, gastro-esophageal reflux disease, uncontrolled hypertension and diabetes mellitus, current smokers, body mass index $> 30 \text{ kg/m}^2$, and female patients on hormone treatment. Written informed consent was obtained from all patients.

All patients were not premedicated. On arrival at the operating room, electrocardiogram, pulse oxygen saturation, non-invasive arterial pressure, end-tidal carbon dioxide (EtCO_2), and bispectral index (BISTM Quatro Sensor; Covidien, Boulder, CO, USA) were monitored. Anesthesia was induced with 4-5 mg/kg of thiopental sodium and 1-5 ng/mL target concentration of remifentanyl (Ultiva, GlaxoSmithKline, Brentford, UK) using TCI for all patients. TCI of remifentanyl was administered with a commercial total intravenous anesthesia pump (Orchestra[®] Base Primea, Fresenius-Vial, France) based on the pharmacokinetic model of Minto.²⁷ On absence of response to a verbal or eye stimulus, rocuronium 0.6 mg/kg IV was administered. Orotracheal intubation was performed in all patients using a 7.0 mm (internal diameter) tracheal tube for females and an 8.0 mm (internal diameter) tracheal tube for males. Cuff pressure was maintained at 20-25 cmH₂O using a hand pressure gauge (Hi-LoTM Hand Pressure Gauge, VBM Medizintechnik GmbH, Germany).

Anesthesia was maintained with sevoflurane vol% 1.5-2.5 and a remifentanyl Ce

of 1–5 ng/mL to maintain a BIS value of 40–55, mean arterial pressure (MAP) and heart rate (HR) within 20% of baseline. Mechanical ventilation was maintained with a tidal volume of 8 mL/kg, air/oxygen mixture (FiO₂: 0.5, 3 L/min) and EtCO₂ at 35–40 mm Hg.

At time of skin suture, sevoflurane was adjusted to an approximate BIS level of 60, and the Ce of remifentanil was titrated to a pre-determined concentration. The Ce was maintained for at least 15 min throughout emergence. At the end of surgery, sevoflurane was discontinued, and fresh gas flow was increased up to 10 L/min. Postoperative analgesics and antiemetics included IV ketorolac 30 mg and ramosetron 0.3 mg, respectively, and IV Bridion[®] (sugammadex) 3 mg/kg was administered for reversal of neuromuscular block, which was re-confirmed as train-of-four ratio > 90% using nerve stimulator. Manual ventilation was initiated with maintaining EtCO₂ of 45–50 mmHg. During this phase, the patients were not stimulated, except for a verbal request to open their eyes. The tracheal tube was extubated on confirming that the patients showed opening of eyes and spontaneous respiration with an adequate tidal volume and respiratory rate. Subsequently, remifentanil infusion was stopped; and oxygen was supplemented via a facemask for at least 3 min. Extubation was performed by a single anesthesiologist with considerable experience with intubation.

Emergence cough was defined as the cough developed during the period of discontinuing sevoflurane and 3 min after extubation. Hemodynamic data, such as HR and MBP, were recorded at baseline (before induction, T₀); end of operation (T₁); just before extubation (T₂); just after extubation (T₃); and 3 min after extubation (T₄). Bradycardia (HR < 40 beats/min) and hypotension (MAP < 60 mmHg) was treated with IV atropine 0.5 mg and ephedrine at 4 mg, respectively. The sevoflurane concentration at time of eye opening was recorded. Time to extubation was defined as the time from discontinuing sevoflurane until extubation. Complication such as bradypnea (RR < 8 bpm), laryngospasm, and desaturation (SpO₂ < 95% despite oxygen supplementation) were evaluated throughout the emergence period. Sedation score was assessed for each patient

on arrival at the recovery room. In addition, overall pain score was evaluated. Pain intensity was evaluated using an 11-point numerical rating scale (NRS; 0 = no pain and 10 = worst pain). Fentanyl 0.5 µg/kg was administered IV in patients who reported an NRS score \geq 5.

For estimation of the remifentanyl Ce, the up-and-down sequential allocation design was used. The initial Ce of remifentanyl was 2 ng/mL for the first patient of each sex, and for the subsequent patient, the pre-determined Ce of remifentanyl was based on the cough response of the previous patient. If the patient did not cough throughout the peri-extubation period, it was considered as 'success', and the pre-determined Ce of remifentanyl for the subsequent patient was decreased by 0.5 ng/mL. If the patient coughed at any time before, during, or after extubation, it was considered as 'failure', and the pre-determined Ce was increased by 0.5 ng/mL.

III. Statistics

The primary endpoint of this study was to investigate the effective concentration of remifentanyl in 50% of the population (EC_{50}) and 95% of population (EC_{95}) for preventing emergence cough following extubation in patients aged 60–75 years in each sex. Since females show different sensitivity to opioid than males,²³ we hypothesized that there is a sex difference in the C_e of remifentanyl for preventing emergence cough.

Based on previous studies in which the EC_{50} was estimated by the Dixon' s method,¹⁸ the stopping rule requires at least 6 success/failure pairs in the same direction. Simulation studies for the up–and–down design suggest that at least 20 patients should be included to obtain stable estimates.²⁸ In our study, 23 and 22 patients were included in male group and female group, respectively, and so there were sufficient numbers to satisfy all requirements.

The EC_{50} of remifentanyl by Dixon' s up–and–down method was defined as the mean value of the independent crossover pairs for each sex, and the mean EC_{50} values of each sex were compared using independent t–test. To specify the precision of the target concentration, the isotonic regression method was also used to estimate the EC_{50} and the EC_{95} of remifentanyl along with the confidence interval (CI). From the observed response rate, which presents the ratio of the number of successful patients to the number of subjects at each concentration, an adjusted response probability was calculated by a pooled–adjacent–violators algorithm (PAVA) in order to adhere to the assumption that the drug effect increases with increased dosage. The CI was estimated by a bootstrapping approach.²⁸ If the EC_{50} and EC_{95} values did not overlap at the level of the 83% and 95% CI, respectively, the null hypothesis of equal effective concentrations was rejected at an α of 0.05.^{28,29}

All values were expressed as the mean \pm standard deviation (SD), median (range) or as the number of patients. The analysis between sexes was performed

using an independent t-test (height, weight, body mass index, anesthesia time, time to extubation), Mann-Whitney U test (age, operation time, sevoflurane vol% at eye opening, and NRS), Chi-squared test (ASA physical status and fentanyl administration), or Fisher's exact test (respiratory complications and sedation score). Repeated measured variables (MAP and HR) were analyzed using repeated measured ANOVA with the Bonferroni correction. A *P* value of < 0.05 was considered statistically significant. Statistical analyses were performed using the Statistical Package for Social Sciences (version 23.0 for Windows; IBM Corporation, Armonk, NY, USA) and R for Windows (version 3.2.5: The R foundation for Statistical Computing; <https://www.r-project.org>).



IV. Results

Among the enrolled 47 patients, 2 male patients were excluded due to delayed skin suturing and an incorrect pre-determined Ce of remifentanyl, and 23 male and 22 female patients were included in the final analysis (Fig. 1). Patient characteristics and operation details are summarized in Table 1. Due to sex-related differences, height and weight were significantly lower in females than in males, but body mass index (BMI) showed no significant difference.

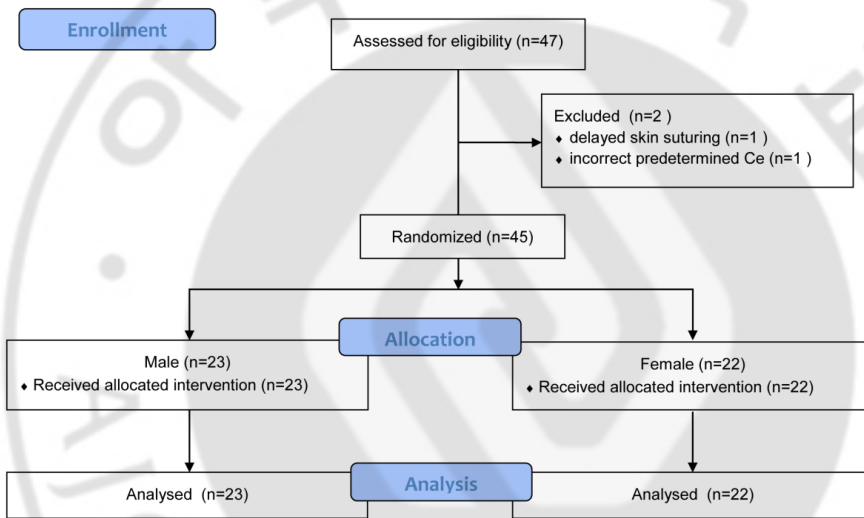


Figure 1. consort diagram

Table 1. Patients characteristics and operation details

	Male group (<i>n</i> = 23)	Female group (<i>n</i> = 22)	<i>P</i> -value
Age (years)	68 (65– 73)	63 (60– 72)	0.120
Height (cm)	166.9 ± 6.0	155.4 ± 5.2	<0.001
Weight (kg)	65.4 ± 6.2	58.8 ± 7.1	0.002

BMI (kg/m ²)	23.5 ± 2.4	24.4 ± 2.8	0.303
ASA physical status (I/ II)	7/16	12/10	0.182
Operation time (min)	40 (25–55)	30 (25–40)	0.276
Anesthesia time (min)	83 ± 26	73 ± 16	0.124
Sevoflurane vol% at eye opening	0 (0–0)	0 (0–0.2)	0.678

Values are mean ± standard deviation, median (range) or number (%).

BMI, body mass index; ASA, American Society of Anesthesiologists.

The sequence of successes and failures determined by Dixon' s up-and-down method is shown in Fig. 2, and the isotonic regression calculated using the PAVA is shown in Fig. 3. The EC₅₀ and EC₉₅ of remifentanil Ce for preventing emergence cough calculated by Dixon' s method or isotonic regression are presented in Table 2. The EC₅₀ of remifentanil Ce estimated by Dixon' s method was lower in females than in males (mean ± SD 1.56 ± 0.26 vs. 2.61 ± 0.38 ng/mL; *P* < 0.001). The EC₅₀ (83% CI) of remifentanil Ce estimated by isotonic regression was 1.67 (1.55–1.83) ng/mL in females and 2.60 (2.29–2.91) ng/mL in males. The EC₉₅ (95% CI) of remifentanil Ce estimated by isotonic regression was 2.30 (2.02–2.62) ng/mL in females and 3.41 (3.27–3.58) ng/mL in males. As the EC₅₀ and EC₉₅ values did not overlap at the level of the 83% and 95% CI, respectively, the Ce of remifentanil for preventing emergence cough was significantly lower in females than in males.

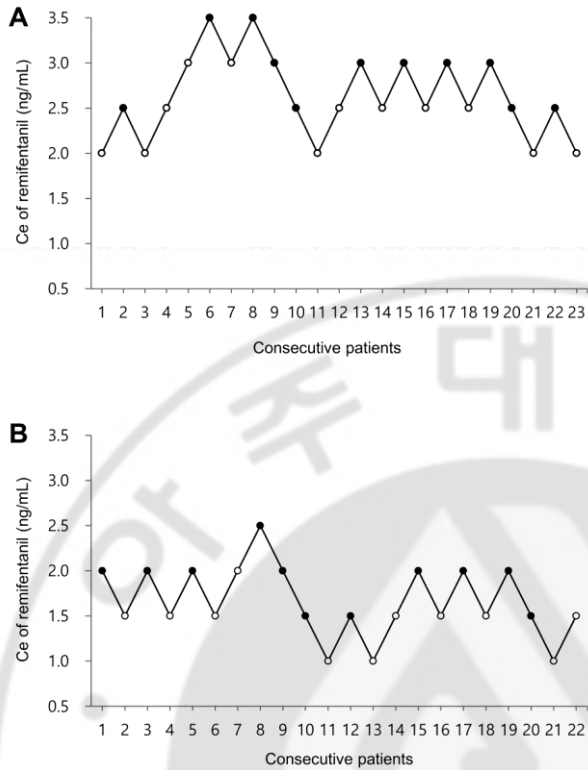


Figure 2. Assessment of success or failure at preventing emergence cough following extubation under the pre-determined remifentanyl Ce in consecutive patients determined by Dixon's up-and-down methods.

The mean EC_{50} of remifentanyl Ce for preventing emergence cough was calculated from cross-over pairs of successes (filled circle) and failures (open circle) in 23 male patients (A) and 22 female patients (B). The mean \pm standard deviation EC_{50} values of remifentanyl Ce values were 2.61 ± 0.38 ng/mL in males and 1.56 ± 0.26 ng/mL in females. EC_{50} is defined as effective concentration for preventing emergence cough following extubation in 50% of patients.

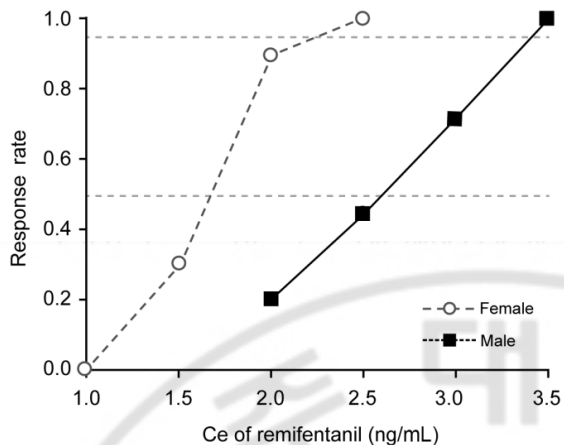


Figure 3. Pooled-adjacent-violators algorithm response rates in females (open circle) and males (filled circle).

The EC₅₀ values (83% CI) of the remifentanyl Ce for preventing emergence cough following extubation were 2.60 (2.29– 2.91) ng/mL in males and 1.67 (1.55– 1.83) ng/mL in females. The EC₉₅ values (95% CI) of remifentanyl Ce for preventing emergence cough following extubation were 3.41 (3.27– 3.58) ng/mL in males and 2.30 (2.02– 2.62) ng/mL in females. Both EC₅₀ and EC₉₅ were significantly lower in the female group than in the male group. EC₅₀ is defined as effective concentration for preventing emergence cough following extubation in 50% of patients. EC₉₅ is defined as effective concentration for preventing emergence cough following extubation in 95% of patients. Ce, effect-site concentration; CI, confidence interval.

Table 2. Effect-site concentration of remifentanyl for preventing emergence cough following extubation

	Male group	Female group
Sex	(n = 23)	(n = 22)
Dixon' s method		
EC ₅₀ of remifentanyl Ce (ng/mL)	2.61 ± 0.38*	1.56 ± 0.26
Isotonic regression method		

EC ₅₀ of remifentanyl Ce (ng/mL)	2.60 (2.29– 2.91) †	1.67 (1.55– 1.83)
EC ₉₅ of remifentanyl Ce (ng/mL)	3.41 (3.27– 3.58) †	2.30 (2.02– 2.62)

Values are mean ± standard deviation determined by Dixon' s method and the EC₅₀ (83% CI) and EC₉₅ (95% CI) determined by the isotonic regression method

Ce, effect–site concentration; CI, confidence interval.

* $P < 0.001$ vs. females (independent t–test)

† Significantly higher vs. females (non–overlapping CI method)

Emergence and recovery profiles are summarized in Table 3. Among respiratory complications, bradypnea was observed in 4 female patients, of which remifentanyl Ce were 1, 1.5, 2, and 2 ng/mL. Desaturation was developed in 1 female patient with remifentanyl Ce of 1.5 ng/mL. Patients returned to a normal respiratory pattern immediately just by encouragement of deep breathing via facial mask without ventilatory support.

MAP and HR during anesthetic emergence and tracheal extubation are shown in Fig. 4. MAP showed no significant difference between sexes (Fig. 4A, $P = 0.271$), but MAP in males was significantly lower at the end of operation (T1), as compared with baseline (T0) value ($P = 0.001$). Similarly, there were no significant differences between sexes in HR (Fig. 4B, $P = 0.723$), and HR in males was lower at the end of operation (T1), as compared with baseline (T0) value ($P < 0.001$).

Table 3 Emergence and recovery profiles

	Male group (<i>n</i> = 23)	Female group (<i>n</i> = 22)	<i>P</i> –value
During emergence			
Time to extubation (min)	13.5 ± 4.1	11.1 ± 5.8	0.114
Respiratory complications			0.053

bradypnea	0	4 (18%)
laryngospasm	0	0
desaturation	0	1 (5%)

At recovery room

Sedation score (1/2)	2/21	1/21	>0.999
NRS	3 (3–5)	4 (3–7)	0.160
Patients receiving fentanyl	5 (22%)	6 (27%)	0.932

Values are mean \pm standard deviation, median (range) or number (%)

NRS, numerical rating scale.

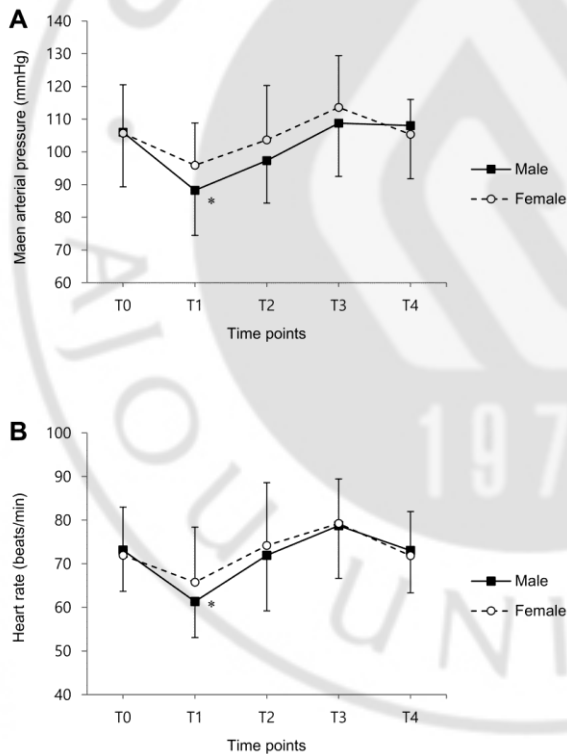


Figure 4. The (A) mean arterial pressure and (B) heart rate during emergence of anesthesia and tracheal extubation.

Data are expressed as the mean \pm standard deviation. * $P < 0.05$ vs. T0 for each sex (Bonferroni corrected). T0, before induction; T1, end of operation; T2, just before extubation; T3, just after extubation; T4, 3 min after extubation.

V. Discussion

In the present study, we implemented balanced anesthesia with sevoflurane and remifentanyl TCI in elderly patients undergoing laparoscopic cholecystectomy in order to find the Ce of remifentanyl in each sex for smooth extubation during anesthetic emergence. The results indicated that the remifentanyl requirement for preventing emergence cough in elderly patients was lower in female subjects (EC_{50} : 1.67 ng/mL) than in male subjects (EC_{50} : 2.60 ng/mL), indicative of sex-related differences.

Cough reflex is mediated by dual sensory neuron (nociceptor and mechanoreceptor) around trachea and brainstem processing of afferent information.³⁰ While anesthesia affects subcortical processing and regulates a voluntary cough, opioid acts at both brainstem and peripheral nociceptor and reduces a reflexive cough.³⁰ Among opioids for general anesthesia, remifentanyl is commonly administered as infusion throughout the anesthesia. It is associated with deeper intraoperative analgesia and anesthesia, faster postoperative recovery, and less respiratory depression compared with short-acting opioids (fentanyl, alfentanil, or sufentanil).³¹ In addition, remifentanyl infusion on anesthetic emergence decreases the emergence cough following extubation.⁷ Several previous studies, with differing types of surgery and combined anesthetics, have demonstrated reduced severity and incidence of anesthetic emergence cough,^{12-14,17} or optimal Ce values of remifentanyl for preventing emergence cough,^{11,16,19} with the use of remifentanyl TCI. However, most these studies neglected sex-related differences regarding Ce of remifentanyl. Recently, Lee et al. reported the Ce of remifentanyl for preventing emergence cough in male (EC_{50} : 2.57 ng/mL) and in female (EC_{50} : 1.30 ng/mL) young patients (aged 20-46 years) and existence of sex-related differences.¹⁸ To our best knowledge, there has been no report showing sex-related difference in the Ce of remifentanyl for preventing emergence cough in elderly patients.

The main result of our study was the sex-related difference in Ce of remifentanyl for preventing emergence cough among elderly patients. The sex-related differences in opioid effect may not be restricted to the pain, but have a same direction with other effects such as emesis, respiratory depression, and cough suppression, since it stems from an inherent property of the endogenous opioid receptor system.²² However, sex-related differences in opioid efficacy in elderly patients in prevention of emergence cough remain unclear.

Female elderly patients required lower Ce of remifentanyl for preventing emergence cough compared to male elderly patients in the present study. Generally, gender is a significant factor influencing opioid requirement during postoperative period,^{22,23,32} although the direction of sex-related differences in opioid efficacy is less clear in human studies because of many interacting variables.²¹ First, sex-related differences in opioid efficacy may contribute sex-related differences in basal pain perception. There is greater deactivation in pain-related brain regions among females.³³ Second, it could result from sex-related differences in sensitivity to opioid. Females differ from males in terms of distribution, expression, or sensitivity of opioid receptors in brain.²³ Third, it could be partially mediated by interaction between gonadal hormones and the opioid system.²³ Gonadectomy reduces analgesia in males but increases analgesia in females *in vivo*.³⁴ In a clinical study, Chia et al. investigated the influence of age on the requirements for postoperative morphine in approximately 2,300 patients, and revealed greater opioid consumption in males than in females.³² This indicates a greater opioid efficacy in female patients.³⁴

The sex-related differences in opioid efficacy are confirmed in young patients, but conflicting in elderly patients.^{23,35} Clinically, Ce of remifentanyl at loss of response to painful stimulus in elderly patients was similar to that in young patients during anesthetic induction.³⁶ In addition, young patients exhibited sex-related differences for postoperative pain and morphine requirement in postanesthesia care unit, but no differences were observed in elderly patients (aged ≥ 75 years).³⁷ These modulations by aging due to the influence of gonadal

steroid hormone sensitivity to opioid analgesia.³⁸ In contrast, a meta-analysis concluded persistence of sex-related differences in opioid efficacy among elderly patients, suggesting that pain circuitry of humans is less regulated by sex hormones compared with animals.²² In present study, elderly patients exhibited sex-related differences in Ce of remifentanil for preventing emergence cough.

There was no great discrepancy in Ce value of remifentanil for preventing emergence cough between elderly patients in present study and young patients in previous study.¹⁸ Although it is hard to compare between two studies because of different conditions including types of surgery, several possibilities may explain the phenomenon. First, elderly patients do not feel less pain than young patients, although the relationship between aging and postoperative pain has not yet been confirmed.³⁵ In Yang's study, remifentanil requirement at loss of response for electrical stimulus using a peripheral nerve stimulator was similar between elderly and young patients.³⁶ Elderly patients tend to have lower pain score and demand less opioid than young patients, despite similar pain intensity.³⁹ Second, the patients in Lee's and present studies underwent different types of surgery: thyroidectomy and laparoscopic cholecystectomy. Different conditions could require different doses of opioid for the desired effect, even though pain intensities of the surgeries are similar [numeric rating scale, 4 (3-6) vs. 5 (3-6) in thyroidectomy and laparoscopic cholecystectomy].⁴⁰

In conclusion, the Ce of remifentanil for preventing emergence cough following extubation was lower in female than in male patients, indicative of sex-related differences in optimal Ce of remifentanil in elderly patients. Sex should be considered when using remifentanil TCI for prevention of emergence cough in elderly patients.

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국문요약

전신마취 후 기관내튜브를 제거할 때 발생하는 기침은 다양한 합병증을 유발할 수 있기 때문에 예방하는 것이 좋다. 레미펜타닐을 목표농도조절주입법으로 투여하면 발관시 기침을 효과적으로 줄여줄 수 있다. 젊은 환자에게서 성별에 따른 레미펜타닐의 적정효과치 농도의 차이는 이미 밝혀져 있다. 본 연구에서는, 노인 환자에서 발관시 기침을 예방할 수 있는 레미펜타닐의 적정효과치 농도를 측정하고 성별에 따른 차이를 평가하고자 하였다.

60~65세의 노인환자, 23명의 남자와 22명의 여자를 대상으로 하였다. 마취는 세보플루란으로 유지하였고 레미펜타닐을 목표농도조절주입법으로 투여하였다. 발관시 기침을 예방하는 레미펜타닐의 적정효과치 농도는 isotonic regression 및 bootstrapping approach, Dixon's up-and-down method를 사용하여 결정되었다.

발관시 기침을 예방하는 레미펜타닐의 적정효과치 농도는 남성에 비해 여성에서 의미있게 낮았다. isotonic regression을 사용하였을 때, 50%의 환자에서 발관시 기침을 예방하는 레미펜타닐의 적정효과치농도(EC₅₀)는 여성에서 1.67(1.55~1.83) ng/mL였고 남성에서 2.60(2.29~2.91)ng/mL였다. EC₉₅는 여성에서 2.30(2.02~2.62) ng/mL였고 남성에서 3.41(3.27~3.58)ng/mL였다. Dixon's up-and-down method로 구한 EC50 또한 여성에서 남성보다 낮았다.(1.23±0.21 ng/mL vs. 2.43±0.21 ng/mL, $P < 0.001$)

노인 환자에서 마취 후 기관내튜브 제거 중 기침 예방을 위해 필요한 레미펜타닐의 요구량은 남성에 비해 여성에서 낮았다. 즉 레미펜타닐의 적정효과치 농도에 있어서 성별에 따른 차이가 있음을 보여주었다. 따라서 노인 환자에서 발관시 기침 예방을 위해 레미펜타닐 목표농도조절주입법을 사용할 때 성별을 고려할 필요가 있겠다.

핵심어 : 목표농도조절주입법, 레미펜타닐, 적정효과치 농도, 성별에 따른 차이