Efficacy of Cardiopulmonary Resuscitation in the Microgravity Environment

Submitted by

Smith L. Johnston, M.D.; Mark R. Campbell, M.D.; Roger D. Billica, M.D.; Stevan M. Gilmore, M.D.

NASA
Lyndon B. Johnson Space Center
Medical Operations Branch
Mail Code SD26
2101 NASA Road
Houston, Texas 77058-3696

Wyle Laboratories, Inc.
Life Sciences Division (Formerly KRUG Life Sciences)
1290 Hercules Drive
Houston, TX 77058-2787

Wright State University
Department of Emergency Medicine
3525 Southern Blvd.
Kettering, OH 45429-1221

Address Reprints

NASA
Lyndon B. Johnson Space Center
Medical Operations Branch
Mail Code SD26
2101 NASA Road
Houston, Texas 77058-3696
(281) 483-0453
**Background:** End tidal carbon dioxide (EtCO₂) has been previously shown to be an effective non-invasive tool for estimating cardiac output during cardiopulmonary resuscitation (CPR). Animal models have shown that this diagnostic adjunct can be used as a predictor of survival when EtCO₂ values are maintained above 25% of prearrest values.

**Hypothesis:** CPR can be administered in the microgravity environment.

**Methods:** Eleven anesthetized Yorkshire swine were flown under the simulated microgravity conditions on a KC-135. Physiologic parameters including EtCO₂ were monitored. Standard Advance Cardiac Life Support protocols were used to resuscitate these models after induction of cardiac arrest. Chest compressions were administered using conventional body positioning with restraint and unconventional vertical-inverted body positioning.

**Results:** EtCO₂ values were maintained above 25% of prearrest values in the microgravity environment (33%± 3 ground and 41%± 3 flight controls). No significant difference in CPR, as monitored by EtCO₂, administered in 1G or 0G on these models was noted (Ground Control : 35± 3% 1-g vs 33± 3% 0-g; Flight Control: 44± 3% 1-g vs 41± 3% 0-g). Effective CPR was delivered in both body positions although conventional body positioning was found to be fatiguing.

**Conclusions:** Cardiopulmonary pulmonary resuscitation can be effectively administered in microgravity. Validation of this model has demonstrated that EtCO₂ levels were maintained above a level previously reported to be predictive of survival. The unconventional vertical-inverted position provided effective CPR and was less fatiguing as compared to the conventional body positioning.

**Key Words:** Cardiopulmonary Resuscitation, End-tidal CO₂, Space Medicine, Advanced Cardiac Life Support, Weightlessness.
Introduction

The inherent risks of space flight are significant. Recently, Johnston et al characterized the medical risks associated with long duration space flight (1). In this analysis, data was abstracted from the Russian Space Program, the Longitudinal Study of Astronaut Health (LSAH), and analog populations such as winter-over groups in Antarctica and military submarine crews. These data showed that for a crew of seven astronauts the incidence of a significant medical event was once every 2.4 years and the incidence of an incapacitating medical emergency was once every 14 years.

Although routinely used, cardiopulmonary resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) (2) are relatively new techniques when viewed from the perspective of the history of medicine (3). Even under optimum circumstances, cardiac and cerebral perfusion pressures are but a fraction of pre-arrest values (4, 5). For this reason, survivability decreases precipitously when the initiation of CPR is delayed. The primary motive force behind the generation of perfusion pressures is related to the increase in intra-thoracic pressures during CPR as opposed to direct cardiac compression (6).

Animal models and human studies have shown that end-tidal CO₂ (EtCO₂) monitoring is an accurate adjunct with which to monitor the efficacy of CPR (7-14). These studies showed that during the low blood-flow states associated with CPR, EtCO₂ monitoring is a reliable detector of pulmonary blood flow and therefore cardiac output (CO). Although preliminary studies suggested this relationship to be linear (14), more recent investigations have shown a near-linear relationship (11). This relationship to CO is important because coronary perfusion, which is a predictor of the return of spontaneous circulation (ROSC), is directly related to CO (15, 16). It is through this link to CO that EtCO₂ has been shown to correlate with cerebral perfusion pressure as well (10).

Recently, human trials have attempted to define an EtCO₂ level that is predictive of survivability after the initiation of CPR (8, 12, 13, 17, 18). In their porcine model, Gudipati et al showed that the ability to maintain EtCO₂ values at greater than 25% of prearrest values was an accurate predictor of survivability (9). The objective therefore of this study was to demonstrate that CPR could be effectively administered in a microgravity environment. EtCO₂ monitoring in addition to monitoring of blood pressure and oximeter levels were used to monitor the effectiveness of CPR in this microgravity model.
CPR is difficult to deliver in the weightless environment, as chest compressions have to be counteracted by the CPR provider. This usually done by gravity in the normal 1-g environment, but in the 0-g weightless environment must be performed by either restraint, bracing, or active muscular counteraction by the CPR provider. Depending on how much active muscular reaction is required, this can be extremely fatiguing.

In addition, in the 0-g environment, CPR can only be performed if there is a method of restraint of the patient, CPR provider, and all equipment. A floor level restraint system was developed for medical restraint in weightlessness and this project was a demonstration of its effectiveness. This Crew Medical Restraint System (CMRS) provided restraint of the animal model, all ACLS equipment and hardware, and methods for CPR provider restraint.

Materials and Methods

Experimentation was conducted as part of a program to assess ACLS and Advanced Trauma Life Support (ATLS) protocols in the microgravity environment. As part of this program, a total of eleven pigs were flown in a modified KC-135, which is able to simulate microgravity. By using parabolic flight, a KC-135 is able to provide forty-second intervals of zero gravity (0-g) followed by a 2-g pullout. A total of eleven flights, one for each porcine model, were conducted with 40 parabolas on each flight. These models were run in groups of three and experimentation was conducted in 1992, 1993, 1996, and 1998.

Yorkshire swine were chosen as the porcine test model. The models had not undergone previous testing. The initial three models were 20-23 kg while the remaining eight weighed 50 kg. Strict adherence to the Standard Anesthetic Regimen, Surgical Training Lab Protocols, and Guide to Care and Use of Laboratory Animals, NIH Publication #86-23 was maintained. In accordance with KC-135 flight rules that prohibit the use of inhalational anesthetics, intravenous pentobarbital was used as the general anesthetic. This study received review, approval, and monitoring by the St. Joseph Hospital Surgical Training Lab Institutional Animal Care and Use Committee (Houston, Texas), by the NASA-JSC Institutional Animal Care and Use Committee (Houston, Texas), and the NASA-JSC Institutional Review Board (Houston, Texas).
Animals were initially prepared at the Surgical Training Lab at St. Joseph's Hospital. After receiving an intramuscular dose of Ketamine (5cc/kg), the swine were orotracheally intubated and initiated on halothane gas general anesthesia. The animal was ventilated with 12-15 breaths per minute with a tidal volume of 10 ml/kg. Each specimen was prepped and draped in a sterile fashion and the central vasculature of the neck mobilized surgically. An arterial line in the carotid artery was placed for blood pressure monitoring followed by the placement of a central line in the jugular vein for the administration of fluids and medications. Peripheral venous access was also obtained via percutaneous introduction of an angiocatheter into an ear vein. The method of general anesthesia was then changed to intravenous with pentobarbital (0.25cc/kg) and paralysis was maintained with Pancuronium (0.09 mg/kg/hour). Maintenance of adequate anesthesia was titrated based on continuous monitoring of vital signs. The porcine models were then transported Ellington Field (Houston, Texas) with a total time for prepping to arrival of 90 minutes. At the completion of all testing, the animals were euthanized using IV Pentothal and disposed of by the Surgical Training Lab at St. Joseph's Hospital.

Each animal was monitored continuously throughout experimentation. A physiologic monitoring module (Spacelabs Medical Inc, Redmond, WA) was used to monitor intra-arterial blood pressure, cardiac rhythm strip, rectal temperature, oximetry (via a tongue-probe), and end-tidal CO2 (Novametrix Medical Systems, Inc., Wallingford, CT). A pneumatically powered ventilator (LAMA), which had been previously rated for microgravity flight was used throughout the study. Due to safety restrictions, compressed air instead of 100% oxygen was used when aboard the KC-135. This provided a SaO2 of 94 ± 1% on the ground and 88 ± 2% at a flight cabin pressure of 6000-8000 feet. Ventricular fibrillation was induced with an intravenous bolus of potassium chloride (KCI). After verifying induction of ventricular fibrillation through cardiac monitoring and drop in arterial blood pressure, chest compressions were performed by several CPR providers. A commercially available defibrillator/pacer unit (Physio-Control Lifepak-10, Redmond, WA), weight-adjusted ACLS medications, and standard ACLS algorithms were then used to regain spontaneous rhythm.

Two methods were used by CPR providers to perform manual chest compressions. The first method was a conventional body position with the CPR provider to the side of the animal model and restrained by waist belts and/or restraint cords across the lower legs (Figure 1). This method required a
large amount of effort by the CPR provider to counteract the force of the chest compressions and was
known to be quickly fatiguing from earlier parabolic flights utilizing manikins. The second method was
with the CPR provider in the unconventional vertical-inverted position with his feet on the ceiling which
allowed for bracing to counteract the force of the chest compressions (Figure 2). Obviously, this position
can only be used during weightlessness. This position was also known from previous parabolic manikin
studies to allow for the performance of CPR with only minimal effort.

Physiologic parameters were measured under the following conditions: 1) ground controls were
obtained preflight at 1-g during normal sinus rhythm (NSR) 2) flight controls obtained in flight at 1-g and
with NSR 3) at altitude during 1-g CPR 4) at altitude during 0-g CPR. Five data points were obtained
under each of these conditions and averaged. The EtCO₂ data is expressed as % of EtCO₂. Data is
presented graphically with 95% confidence intervals included. T-tests are used where P-values are
computed.

Results

Figure 3 contains a sample graph of the physiologic parameters monitored during each KC-135
flight. Note that the onset of ventricular fibrillation, which was induced by intravenous potassium chloride,
was immediately reflected in the vital signs. During each flight, the porcine model was oriented in parallel
with the long axis of the airplane.

Mean oximeter readings are reported in Figure 4. As was documented previously, due to flight
rules supplemental oxygen was not available during the KC-135 flight. This was reflected in the oximeter
readings that are taken at an effective altitude of 6-8000 feet above sea level. This resulted in a significant
change in the SaO₂ readings with a mean ground control reading of 94 ± 1% and a mean flight control
reading of 89 ± 2% (P= 0.0001). No statistically significant differences were noted between the oximeter
readings taken during CPR in the micro- or normogravity. The oximeter readings for both CPR groups
were significantly lower than both controls.

Figure 5 presents the EtCO₂ results in terms of percentage of control. Both the percentage of
group and flight controls are presented for analysis. These data show that CPR in the microgravity
environment was able to sustain EtCO₂ values well above 25% of prearrest values when compared to both
the ground and flight controls. No significant differences in mean EtCO₂ readings were noted between
CPR performed under 1-g or 0-g when comparing the ground (35 ± 3% 1-g vs 33 ± 3% 0-g) and flight (44 ± 3% 1-g vs 41± 3% 0-g) control results separately. There was a trend towards statistical significance noted between EtCO2 readings of the ground versus flight CPR results. Although statistically significant, the difference between these two values would be of questionable clinical significance as Gudipati was not able to demonstrate any relationship between survivability and EtCO2 readings beyond an increased likelihood of survival above the 25% of prearrest value (9).

The mean intra-arterial blood pressure results are presented in Figure 6. As expected, the onset of ventricular fibrillation produced a significant change in pressure. No other significant trends in the mean blood pressure were noted during CPR conducted in either the micro or normogravity settings.

There was no difference in any of the monitored parameters (SaO2, EtCO2, and intra-arterial BP) between the two methods of chest compression.

Discussion

This study has several limitations. First, while the KC-135 provides the most representative microgravity experience without actually being in orbit, the duration of 0-g exposure during each parabola is only 30 seconds. As noted previously, one KC-135 flight typically consists of forty such parabolas. Interposed between each 0-g parabola of periods of up to 2-g. To maximize the effect of microgravity on this model, all readings taken under microgravity conditions were recorded 25 seconds into each parabola to maximize the effect of 0-g. Classically, physiology texts teach that carbon dioxide diffusion across the lung parenchyma is essentially instantaneous (19). It is not clear how the low flow states associated with CPR impact this relationship. Some studies have suggested that the diffusing capacity of CO2 is delayed. It is not clear to what extent this impacts our investigation.

As noted previously, oxygen supplementation was not provided during in-flight experimentation due to airplane safety restrictions. Administration of high-flow oxygen is one of the basics of resuscitation and is standard of care in terrestrial medical operations. Additionally, our investigations were performed under the hypobaric environment (10.7-11.7 psi) provided in the KC-135. Despite the absence of optimum oxygenation, the ability to maintain EtCO2 levels above a prescribed level was demonstrated.
The International Space Station is designed with 14.7 psi or 1 atmosphere of pressure and supplemental oxygen will be available.

A final limitation is that these porcine models were also used to test ATLS techniques. All of these procedures, including chest tubes and peritoneal lavage, were completed prior to ACLS Mega-code testing. This sequence is routinely performed in medical residency animal training procedures. It is not clear what if any affect these other investigations had on experimental results. However, with consideration to the presented results, it would suggest that our results weren’t adversely biased. Furthermore, although these models were not deconditioned as would an analogous astronaut be, it does suggest that this can be successfully performed on an individual with significant trauma.

This study demonstrated several important findings. First, as demonstrated by decrements in oximeter results during CPR, supplemental oxygen would be an important adjunct for any scenario requiring these procedures. Furthermore, should subsequent transport be required, several studies have documented further decrements in oximeter readings and arterial PaO2 values in healthy individual exposed to the hyper-gravity conditions associated with orbital reentry(20, 21). These parameters would be further compromised in a medically incapacitated patient and oxygen supplementation would assist in optimizing outcome.

Second and most importantly, with respect to the predictive capabilities of EtCO2 and survivability, Gudipati reported that EtCO2 values less than 25% of prearrest were predictive of mortality(9). Tervino, in a similar porcine study, showed comparable results (22). This study demonstrates no significant differences between EtCO2 values obtained during CPR under 1-g and 0-g conditions. More importantly, in both of these experimental CPR conditions, the EtCO2 percent of control was maintained well above the 25% described previously. This was demonstrated both in our ground and flight control conditions. Due to the relationships between EtCO2, CO, and cardiac perfusion pressures as well as link between the percentage EtCO2 and survivability, we believe that this supports the hypothesis that effective CPR can be delivered in the microgravity environment.

Both methods of chest compressions, the conventional body position with restraints and unconventional vertical-inverted, were found to provide adequate and equivalent CPR. However, the conventional method was quickly fatiguing and the unconventional vertical-inverted method required
minimal effort by the CPR providers. As the dimensions of the KC-135 cabin are similar to the interior dimensions of the ISS modules, the vertical inverted method is a suitable technique for the administration of chest compressions during CPR in space flight. Current designs, however, will utilize the conventional restrained configuration in conjunction with the crew medical restraint system so as to place the health-care provider in close proximity to the patient for concerns regarding maintenance of airway, drug administration and other therapeutic considerations.

Although beyond the scope of this discussion, this investigation has resulted in the adaptation of ACLS Mega-code procedures and validation of space-rated hardware for inclusion in the International Space Station’s Health Maintenance System (HMS). During the course of this investigation a defibrillator, intravenous fluids and medications, and a ventilator were reliably used and manifested for space flight. A floor level Crew Medical Restraint System (CMRS) was demonstrated to be able to provide adequate restraint for the performance of ACLS by providing for patient, hardware, and CPR provider restraint. The inclusion of these devices in the HMS will extend the medical capabilities to provide care for the critically ill and/or injured.

Finally, validation of this microgravity CPR model has allowed for its use as a training model. Currently, the crew medical officer (CMO) is trained to have at least emergency medical technician capabilities and may in some cases be a physician depending on the individual. Two individuals have received training on this model prior to their shuttle flights. Additionally, investigations into the utility of EtCO₂ during CPR have also shown that it can be effectively used to monitor fatigue and effectiveness of compression being administered (23-25). Preflight training on this model would allow a CMO to become familiar with the actual mechanics of performing cardiac compressions in microgravity as well as providing exposure to and familiarization with on-orbit hardware. This in combination with proposed on-orbit computer training modules (26), could provide a means for future long-duration crews to obtain and maintain medical proficiencies.

In conclusion, this investigation into CPR in microgravity has demonstrated 1) the ability of maintain EtCO₂ values above previously reported values predictive of survivability in both the 1G and 0G models 2) no change in mean intra-arterial pressures generated by external cardiac compression during
CPR in microgravity 3) decrements in oxygen saturation related to our experimental conditions and 4) demonstrated effective administration of CPR in both the conventional and vertical-inverted positions.

Acknowledgements:

The authors would like to recognize the following institutions for their significant contributions without which completion of this project would not have been possible: 1) St. Joseph Hospital, Surgical Training Lab 2) NASA Reduced Gravity Flight, KC-135 Flight Office.

Additionally, we would like to recognize the following individual for their significant contributions to the completion of this project: from St. Joseph’s Hospital, Amado Ruiz, M.D., Leah Davis, Amy Mills, Leslie Yarborough, D.V.M., F. Eichstadt; from the Lyndon B. Johnson Space Center William Norfleet, M.D., Brad Beck, M.D., Ron Robinson, Michael Barrat, M.D., and Richard Jennings, M.D.; from Wyle Life Science (formerly KRUG) Dave Ward, M.D.; and Ezra Krucharz, Brenda Rouse, Scott Simmons, Charles Lloyd, Ph.D., and Doug Ball, M.D.

References:


Figure 1: Conventional Restrained CPR
Figure 2: Vertical-Inverted CPR
Figure 3: ACLS Code Summary

Physiologic Parameters in mmHg, %, Gs, and beats/min

- Gs
- ETCO2
- Mean BP
- Pulse
- SaO2

Time in Minutes

KCL
CPR
ET Tube Epi
IV Beryllium
IV Ca
IV Epi
Return of Pulse

Defib 50 js
Defib 100 js
Defib 50 js
Defib 200 js
CPR + IV Epi

Stop CPR

IV Atropine + CPR
Stop CPR
Figure 4: Oxygen Saturation During CPR
Figure 5: EtCO₂ During CPR
Figure 6: Mean Blood Pressure

![Bar chart showing mean blood pressure levels across different conditions: Ground Control, Flight Control, 1G CPR, 0G CPR. The chart indicates higher mean blood pressure levels in Ground Control and Flight Control compared to 1G CPR and 0G CPR.]