Comparative Analysis of Antioxidant Defense During On-Pump and Off-Pump Cardiac Surgery

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Introduction and objectives. The transient myocardial ischemia that occurs during cardiac surgery leads to oxidative stress and the production of free radicals. The resulting damage can be reduced if cardiopulmonary bypass is avoided. We obtained indirect measures of the oxidative damage occurring during cardiac surgery by monitoring the glutathione system and we studied the influence of cardiopulmonary bypass.

Patients and method. The study included 19 patients undergoing cardiac surgery. Cardiopulmonary bypass was used in 9 (47.4%). Blood samples were obtained from each patient at different times during and after surgery. Total, oxidized and reduced glutathione levels were measured, as was the activity of related enzymes (i.e., glutathione peroxidase, glutathione reductase, and glutathione transferase).

Results. The total glutathione level decreased more in patients in whom cardiopulmonary bypass had been used. In addition, the oxidized glutathione level was reduced in these patients, which suggests that antioxidant defense was not fully effective. In contrast, the oxidized glutathione level tended to increase in patients in whom cardiopulmonary bypass had not been used. There was no significant difference in enzymatic activity between the two groups.

Conclusions. In this study, patients who underwent off-pump cardiac surgery had a better antioxidant profile. The implication could be that cardiac surgery without cardiopulmonary bypass has a less damaging effect on ischemic myocardium.

surgery, \(^5\) in which cardiopulmonary bypass can affect nearly all the organ systems, provoking lesions of varying degrees of severity. This injury is due, at least in part, to the phenomenon of “ischemia-reperfusion”; that is, both the interruption and the subsequent restoration of the blood flow that can have deleterious effects. \(^6,11\)

Surgically induced myocardial ischemia, although transient, provokes the release of potentially toxic oxygen free radicals as part of a complex inflammatory cascade that progresses toward the site of the tissue injury. \(^5,12-17\) Triggering complications as it develops. \(^1,12\) To combat the oxidizing or toxic effect of these free radicals, the organism launches a series of defensive (antioxidant) mechanisms that may or may not be effective or sufficient. Thus, the phenomena of oxidative stress are determined by the imbalance between oxidants and antioxidants, due either to an increase in the production of the former or to an inadequate neutralization on the part of the latter. \(^1,2,5,18,19\)

On the other hand, improvements in anesthetic and surgical techniques are continually being introduced in the attempt to prevent or reduce the deleterious effects of the pump employed in cardiopulmonary bypass (CPB). In this context, cardiac surgery without CPB is becoming increasingly widespread, with very promising results in terms of morbidity and mortality. \(^20-22\) Probably because it is associated with lower levels of oxidative stress. \(^23\) However, there are few studies comparing the two surgical techniques and providing a basis for this assumption. \(^15,16,22,24-28\)

To estimate the damage associated with each type of cardiac surgery, the direct measurement of markers of oxidative stress (lipid peroxidation) \(^5,16,18,19,29\) and the analysis of antioxidant defense \(^30-35\) are equally valid approaches. This report deals with the comparative analysis of the phenomena involved in oxidative stress during cardiac surgery with and without CPB. For this purpose, we assessed an antioxidant system, the glutathione complex, which acts as an “interceptor,” that is, it reacts directly with the free radicals to impede their action. The determination of glutathione concentrations provides information on its deposition in cells (erythrocytes) and plasma, as well as on the functional status of said system.

**PATIENTS AND METHOD**

**Patients and Anesthetic Technique**

In this study, we analyzed 19 cardiac operations performed in our hospital between October 2001 and September 2002. Cardiopulmonary bypass was employed in nine cases (47.4%) and all of the procedures were elective. Since the choice of the technique to be used was always made by the surgeon responsible for carrying it out, it was not possible to randomize the 2 groups; however, inclusion in the study was random (it is to be supposed that the number of operations during that period of time was much larger). The clinical characteristics of the patients are summarized in Table 1. All of them presented a contractility of more than 45% (mean ± standard deviation [SD], 61.5±8.6%) and stenosis of at least 2 coronary arteries. The antiangiial therapy was the maximum tolerated by each patient and none of them presented comorbidity of interest.

The anesthetic technique always consisted of:

- Premedication with scopolamine and morphine in the hospital ward.
- Induction with etomidate, midazolam, and fentanyl.
- Maintenance on controlled mechanical ventilation with fentanyl, anesthetic gases (sevoflurane for off-pump procedures and isoflurane for on-pump surgery),

**TABLE 1. Clinical Profile of All the Patients Included in the Study**

<table>
<thead>
<tr>
<th></th>
<th>On-Pump</th>
<th>Off-Pump</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>Age, mean ± SD, years</td>
<td>63.67±14.14</td>
<td>63.50±0.71</td>
</tr>
<tr>
<td>Sex, men/total</td>
<td>5/9</td>
<td>6/10</td>
</tr>
<tr>
<td>Hypertension, n</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Diabetes, n</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Smoker, n</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Previous myocardial infarction, n</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Ejection fraction, mean ± SD</td>
<td>63.67±14.14</td>
<td>59.50±2.12</td>
</tr>
<tr>
<td>CPB time, mean ± SD, min</td>
<td>95.1±19.6</td>
<td>–</td>
</tr>
<tr>
<td>Ischemia time, mean ± SD, min</td>
<td>70.7±15.6</td>
<td>–</td>
</tr>
<tr>
<td>Combined surgery, n</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Recovery room stay, median, days</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Postoperative atrial fibrillation, n</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Morbidity and mortality, n†</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Heart failure, n</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Myocardial ischemia, n</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Infection, n</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Mortality, n</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

*CPB indicates cardiopulmonary bypass; SD, standard deviation.
†Excluding atrial fibrillation.
and nondepolarizing muscle relaxants like atracurium or cisatracurium. Aprotinin, at a dose of 2 000 000 units, was utilized in all the procedures involving CPB.

- Immediate postoperative period: all the patients were unconscious and on mechanical ventilation upon arrival in the recovery room and were maintained in that state until the anesthetic drugs had been metabolized, after which they were extubated if their hemodynamic and respiratory statuses were satisfactory.

Seven blood samples were obtained at different time points during the operation and the immediate postoperative period (Table 2).

Sample Processing

Determination of Glutathione Concentrations

Total glutathione (TG) and oxidized glutathione (GSSG) were determined by spectrofluorometry (Hissin and Hill technique, 1976). Via mathematical fitting of the data (for a 1:5 dilution), we obtained:

\[
\text{Glutathione} = \frac{\text{Glutathione [nmol/100 µl]}}{\text{Erythrocyte hemoglobin}} \times 273.5
\]

and the results were expressed in µmol/erythrocyte hemoglobin.

Reduced glutathione (GSH) was calculated as TG minus GSSG, and the percentage of GSSG was determined using the equation:

\[
\% \text{GSSG} = \frac{\text{GSSG} \times 100}{\text{GSH} + \text{GSSG}}
\]

**TABLE 2. Blood Sampling***

<table>
<thead>
<tr>
<th>Collection Site</th>
<th>On-Pump Group</th>
<th>Off-Pump Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Radial artery</td>
<td>At cannulation of the artery</td>
<td>At cannulation of the artery</td>
</tr>
<tr>
<td>2 Radial artery</td>
<td>After intubation, 15 min after initiation of mechanical ventilation</td>
<td>After intubation, 15 min after initiation of mechanical ventilation</td>
</tr>
<tr>
<td>3 Pulmonary artery</td>
<td>After sternotomy, once the pericardium was secured</td>
<td>After sternotomy, once the pericardium was secured</td>
</tr>
<tr>
<td>4 Pulmonary artery</td>
<td>Initiation of CPB, 10 min after establishment of total CPB</td>
<td>Initiation of ischemia, 10 min after placement</td>
</tr>
<tr>
<td>5 Pulmonary artery</td>
<td>After CPB, at initiation of mechanical ventilation</td>
<td>Five minutes after bridge aperture</td>
</tr>
<tr>
<td>6 Pulmonary artery</td>
<td>Upon arrival in recovery room, 100% monitoring</td>
<td>Upon arrival in recovery room, 100% monitoring</td>
</tr>
<tr>
<td>7 Pulmonary artery</td>
<td>The next day at 9:00 h</td>
<td>The next day at 9:00 h</td>
</tr>
</tbody>
</table>

*CPB indicates cardiopulmonary bypass.

**TABLE 3. Enzyme Activity Analyzed**

<table>
<thead>
<tr>
<th>Enzyme</th>
<th>Function</th>
<th>Method of Determination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glutathione peroxidase (GSHpx)</td>
<td>Indicates glutathione oxidation</td>
<td>Flohé and Gunzler, 1984</td>
</tr>
<tr>
<td>Glutathione transferase (GSHtf)</td>
<td>Neutralizes free radicals with –SH groups</td>
<td>Warholm, 1985</td>
</tr>
<tr>
<td>Glutathione reductase (GSSGrd)</td>
<td>Recovers depleted glutathione</td>
<td>Bradford</td>
</tr>
</tbody>
</table>

Determination of Glutathione-Related Enzymatic Activity

This determination provides information on the capacity of the system to react to a possible injury. Kinetic spectrophotometry was employed to analyze the 3 major enzymes involved in glutathione balance (Table 3).

Statistical Analysis

The statistical analysis was done using the SPSS (Social Program for Statistical Sciences) software package for Windows 98, version 9.0 (SPSS Inc., 1999). The results reported in the text, tables, and figures are expressed as the mean ± standard deviation (SD).

Once the homoscedasticity (equality of variance) of the groups was established, one-way ANOVA was used for the comparison of the means obtained in the different samples, followed by intergroup comparison to detect significant differences. \( P<.05 \) was considered to indicate a statistically significant difference. The corresponding association coefficients were also calculated to enable the determination of the potential influence of clinical, epidemiological or surgery-related factors.

RESULTS

Patients

All the procedures involved conventional complete revascularization and included the left anterior descending coronary artery. We obtained as many grafts as possible from the 2 mammary arteries, occasionally
using the radial artery as well. The results are summarized in Table 1. The partial ischemia times for the shunting of each artery were not recorded in the group that did not undergo CPB. In one of these patients, carbon dioxide laser was also employed during the procedure and, in 6 of those who underwent CPB, concomitant valve replacement was performed.

The incidence of major complications was similar in the 2 groups and was easily resolved in most cases. One patient died 13 days after undergoing surgery without CPB; he had small native coronary arteries and basal left ventricular dysfunction (with an ejection fraction of 46%), and presented perioperative acute myocardial infarction owing to the poor quality of the grafts. The overall mean length of stay in the recovery room was longer in the group without CPB (5.0±3.1 days vs 3.7±1.1 days), although if we exclude the patient who died, the difference between the 2 values is less marked (4.1±1.4 days vs 3.7±1.1 days).

**Sample Analysis**

The 2 groups differed with respect to the plasma TG concentration (Figure 1). Although the initial levels were similar (16.2±2.6 µmol/min in the CPB group vs 17.2±2.4 µmol/min in the group without CPB), that of the CPB patients decreased progressively until the moment of reperfusion, when the maximal inhibition was reached (sample 5). This trend was noted in the off-pump patients, but was less marked. The reduction in TG may indicate an impairment of the antioxidant defenses of the CPB patients, or could be attributed to the depletion of glutathione in the attempt to offset the peroxide overproduction provoked by the surgical procedure.

To clarify this issue, we determined the percentage of TG that corresponded to GSSG and the percent change with respect to the baseline value (Figure 2). The plasma GSSG increased in the off-pump patients, whereas it decreased in the on-pump patients.
The same analyses were performed to assess the intraerythrocytic glutathione (Figures 3 and 4) with results similar to those obtained in plasma. Both determinations revealed a trend toward decreased levels in the CPB group. On the other hand, in the off-pump group, there was an increase in glutathione oxidation that did not result in the depletion of the total content.

The behavior of the enzymes related to this system was analyzed (Table 4). There were no significant changes in the glutathione peroxidase (GSHpx) or glutathione transferase (GSHtf) activity during surgery; in contrast, a reduction was observed in the glutathione reductase (GSSGrd) activity, a circumstance that may be interpreted as an attempt to maintain glutathione in the oxidized form (for better defense). There were no significant differences between the 2 groups, although the trend toward a decrease in GSSGrd was slightly more marked in the on-pump patients.

Finally, the association coefficients calculated for a history of infarction and for combined surgery and the correlation coefficient for the ejection fraction were not significant.

**Figure 3.** Percentage of intraerythrocytic total glutathione, expressed as the mean ± standard deviation of the absolute values (left) and the percentages (right). Both values increase during ischemia in patients without CPB, exhibiting the opposite behavior in patients with CPB (see text). CPB indicates cardiopulmonary bypass; GSH, reduced glutathione; GSSG, oxidized glutathione.

**Figure 4.** Percentage of intraerythrocytic oxidized glutathione, expressed as the mean ± standard deviation. This value increases in the group without CPB, and shows a marked decrease during ischemia in patients with CPB. CPB indicates cardiopulmonary bypass.

**TABLE 4.** Activity of the 3 Major Enzymes Involved in the Glutathione-Dependent Antioxidant System

<table>
<thead>
<tr>
<th>Sample</th>
<th>Off-Pump</th>
<th>On-Pump</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Glutathione peroxidase activity, mean ± SD, µmol/min</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>53.80±4.44</td>
<td>54.61±5.64</td>
</tr>
<tr>
<td>2</td>
<td>54.33±6.28</td>
<td>51.80±7.25</td>
</tr>
<tr>
<td>3</td>
<td>56.00±4.43</td>
<td>52.41±5.58</td>
</tr>
<tr>
<td>4</td>
<td>55.55±4.68</td>
<td>49.67±3.26</td>
</tr>
<tr>
<td>5</td>
<td>52.37±6.24</td>
<td>51.22±5.13</td>
</tr>
<tr>
<td>6</td>
<td>55.83±6.08</td>
<td>53.37±5.66</td>
</tr>
<tr>
<td>7</td>
<td>53.67±5.94</td>
<td>54.25±5.54</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Glutathione reductase activity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>12.64±1.13</td>
</tr>
<tr>
<td>2</td>
<td>11.88±0.7</td>
</tr>
<tr>
<td>3</td>
<td>9.49±0.99</td>
</tr>
<tr>
<td>4</td>
<td>8.24±0.77</td>
</tr>
<tr>
<td>5</td>
<td>6.81±0.54</td>
</tr>
<tr>
<td>6</td>
<td>6.42±0.70</td>
</tr>
<tr>
<td>7</td>
<td>9.87±0.92</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Glutathione transferase activity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>22.50±1.93</td>
</tr>
<tr>
<td>2</td>
<td>22.02±1.46</td>
</tr>
<tr>
<td>3</td>
<td>19.25±2.03</td>
</tr>
<tr>
<td>4</td>
<td>20.83±1.64</td>
</tr>
<tr>
<td>5</td>
<td>29.83±2.59</td>
</tr>
<tr>
<td>6</td>
<td>28.32±2.55</td>
</tr>
<tr>
<td>7</td>
<td>25.28±2.00</td>
</tr>
</tbody>
</table>

*CPB indicates cardiopulmonary bypass.
DISCUSSION

Surgery involving the myocardium almost unavoi-
dably provokes an increase in the general markers of
inflammation and in other specific parameters, such as
the MB (muscle/brain) isoenzyme of creatine kinase
(CK-MB) or troponin. These findings are common to all
cardiac surgical procedures, even in uncomplicated
cases and in the absence of evidence of myocardial infarction. In a generic sense, the inten-
sity and characteristics of this response can depend on
the type of surgery (with or without CPB) and, theore-
tically, it is more intense in those cases in which CPB is employed, in fact, in the earliest publica-
tions the MB (muscle/brain) isoenzyme of creatine kinase
inflammation and in other specific parameters, such as
ck-provokes an increase in the general markers of
myocardial infarction.

With regard to the enzymatic activity involved, the
information in the literature is widely discrepant, making it impossible to define patterns of more or less
deterious behavior. The behavior of GSHPx is usually stressed. In any case, in our series, none of the enzymes analyzed underwent important modifi-
cations, a circumstance that we attribute to the small sample size.

On the other hand, in off-pump operations, the me-
chanism of ischemic injury is not as clear. Theoreti-
cally, when the pump is obviated, all its effects are avoided, aortic clamping, cardioplegic arrest and
continuous flow are not employed and, thus, the ische-
emia-reperfusion phenomenon could be confined to
each artery, which is “stabilized” when it is about to
be revascularized, meaning that, a priori, there should be less damage. In contrast, the manipulation and rota-
tion of the heart to gain access to and implant shunts in
the coronary arteries situated on the posterior and
lateral aspects of the heart may lead to torsion of the
vascular pedicle, causing considerable ischemia which
counteracts the benefits. Moreover, there is too little
scientific evidence supporting the superiority of one
option or the other. What does appear to be clear is
that the damage is less severe and the antioxidant defense is not as impaired or, at least, is not overwhel-
med by the oxidative agents. Consequently, the morbi-
dity and mortality associated with this procedure is re-
duced.

Our results agree with this analysis of the situation
and outline differences in favor of off-pump surgery in
that the bypass induces the formation of vast numbers
of free radicals that ultimately overwhelm the antioxi-
dant systems and result in a situation of oxidative stress,
whereas off-pump procedures permit a more active and
effective antioxidant defense (Figures 1–4). Although our data on lipid peroxidation have yet to be published,
they correlate with the findings of the present report
(more intense peroxidation in the CPB group). On the
one hand, the plasma TG and GSSG levels demonstrate
that the patients with CPB did not have an effective an-
tioxidant defense (defined as the transformation of the
reduced form into the oxidized form). On the other
hand, glutathione depletion was less marked in off-
pump surgery than in interventions involving CPB; mo-
over, the glutathione consumed was used in an active
antioxidant defense. Thus, the patients who undergo
off-pump surgery present a better plasma antioxidant
profile than those subjected to CPB. Likewise, the re-
duction of the erythrocyte antioxidant concentration in
patients with CPB reflects the inefficiency of this antioxi-
dant system, whereas its enhancement in patients with-
out CPB clearly indicates an active antioxidant defense
against the production of free radicals.

Meanwhile, the attempt has been made to attribute
the differences observed in the oxidative status in the 2
types of surgery to different external conditions. A
number of authors have attempted, with varying de-
grees of success, to relate the severest inflammatory
responses and the development of complications with
factors like smoking, alcohol consumption, age, left
ventricular systolic dysfunction, poorly control-
led diabetes, the extension of ischemic heart dise-

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a, hemodynamic instability at the start of surgery, It is generally accepted that a thorough preoperative risk assessment enables the correct estimation of the morbidity and mortality. In any case, the more markedly reduced contractility in patients without CPB would lead us to expect worse results in terms of antioxidant defense, but this assumption contrasts with our findings, a circumstance that suggests that we should seek an explanation directly associated with the operation.

With respect to surgical factors, in our case, we rule out the potential influence of the anesthetic management, as it was the same in all the patients. In almost all certainty, the duration of ischemia and of CPB are the most evident differentiating factors and probably the only ones that can be easily justified. There is evidence of positive correlations between CPB time and the release of oxygen free radicals and the postoperative CK-MB concentration, and between longer CPB times and higher complication rates. All in all, the differences observed are best explained by the characteristics of each of the 2 procedures, the mechanisms of injury, which have been discussed here. Although it is certain that we have not recorded the partial ischemic times, it seems logical that the sum of the partial times in the group without CPB will be less than the time required for operations with CPB. On the other hand, there are contradictory reports in the literature with regard to valve surgery although, in our case, in contrast to what we had expected, combined surgery per se was not associated with a less effective antioxidant defense, nor did these patients have a comparatively poorer outcome.

Finally, we point out 2 essential limitations of this study. The first is the small sample size. A larger number of patients would probably enable us to accentuate the differences observed (although in some aspects, they are significant as is) and would dilute data such as the mortality in which, while there was only one case, it elevated the incidence to 10% of the group to which the patient belonged. For this reason, we do not consider the morbidity and mortality rates recorded to be discouraging, since many of the adverse events were rapidly resolved. This circumstance is reflected in the length of stay in the recovery room, which was shorter than the average of 4 to 5 days registered in Spain in recent years.

The second limitation is the paucity of information on the course following discharge from the recovery room. We consider that this matter should be addressed in another study, and prefer to limit this analysis to the surgical procedure and the immediate postoperative period.

CONCLUSIONS

In our series, we observed differences involving the behavior of the glutathione system in that the patients who did not undergo CPB presented a better antioxidant profile. This may indicate that off-pump cardiac surgery is less damaging to the myocardium.

REFERENCES


