Dynamic blood oxygen indices in mechanically ventilated COVID-19 patients with acute hypoxic respiratory failure: a cohort study



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Introduction

Acute hypoxic respiratory failure is a hallmark of severe COVID-19 pneumonia and often requires supplementary oxygen therapy.¹ Critically ill COVID-19 patients may require invasive mechanical ventilation, which carries significant morbidity and mortality.² Understanding of the relationship between dynamic changes in blood oxygen indices and clinical variables is lacking. We evaluated the changes in blood oxygen indices – partial pressure of oxygen in arterial blood (PaO₂), PaO₂/fraction of inspired oxygen (FiO₂) ratio, oxygen content (CaO₂) and oxygen extraction ratio (O₂ER) - in COVID-19 patients through the first 30-days of intensive care unit (ICU) admission and explored relationships with clinical outcomes.

Methods

We performed a retrospective observational cohort study of all adult COVID-19 patients in a single institution (ethics through REACT COVID-19³) requiring invasive mechanical ventilation between March 2020 and March 2021. We collected baseline characteristics, clinical outcomes and blood oxygen indices. 50,505 blood gas data points were obtained from 184 patients over 30-days.

Results

184 patients met inclusion criteria, providing 34,592 arterial blood gas data points over 30-days. Patient characteristics and outcomes are presented in Table 2. The median age was 59.5 (IQR 51, 67), and median BMI 30 (IQR 25.8, 35.5). The majority were men (62.5%) of white ethnicity (70.1%). Median mechanical ventilation duration was 15-days (IQR 8, 25) and 133 patients (72.3%) survived 30-days. Oxygen indices are presented in Table 1. Non-survivors exhibited lower oxygen extraction; there was an averaged mean difference in O₂ER of -0.06 (95% CI -0.09, -0.03) across days one to seven and -0.09 (95% CI -0.10, -0.07) across days one to 30. While both survivors and non-survivors had subphysiological CaO₂ (which trended down throughout their ICU admission), non-survivors tended to exhibit higher values; there is an averaged mean difference of 0.23 (95% CI 0.13, 0.34) across day one to day seven and 0.28 (95% CI 0.21, 0.35) across days one to 30.

	Survivors	Non-survivors	Mean Difference	95% CI	p-value*
PaO ₂ (kPa)					
Day 1.7	0.80	0.40	0.21	0.41 0.20	<0.01
Day 1-7	9.80	9.49	-0.31	-0.41, -0.20	<0.01
Day 1-30	9.73	9.21	-0.52	-0.59, -0.46	< 0.01
PaO ₂ (kPa) / FiO ₂ ratio					
Day 1-7	19.74	17.51	-2.23	-2.55, -1.91	< 0.01
Day 1-30	21.19	15.56	-5.64	-5.85, -5.43	< 0.01
CaO ₂ (ml/dL)					
Day 1-7	14.33	14.63	0.31	0.19, 0.42	< 0.01
Day 1-30	12.78	13.62	0.83	0.75, 0.91	<0.01
O ₂ ER					
Day 1-7	0.34	0.27	-0.07	-0.09, -0.04	< 0.01
Day 1-30	0.38	0.29	-0.08	-0.09, -0.07	<0.01

Table 2. Comparison of mean averaged blood oxygen indices. Day oneseven, and day one-30; survivors (n=133) vs. non-survivors (n=51). * adjusted using the Benjamini-Hochberg Procedure



Variables	All patients n=184	Survivors n=133	Non-survivors n=51	p-value	
Age	59.5 (51.0, 67.0)	57.0 (49.0, 64.0)	65.0 (59.5,72.0)	< 0.01	1
Sex, n (%) Male Female	115 (62.5%) 69 (37.5%)	79 (59.4%) 54 (40.6%)	36 (70.6%) 15 (29.4%)	0.18	
BMI (kg/m ²)	30.0 (25.8, 35.5)	30.1 (25.2, 35.8)	29.4 (26.6, 33.8)	0.75]
Ethnicity, n (%) White Asian Black Mixed Unknown	129 (70.1%) 31 (16.8%) 14 (7.6%) 6 (3.3%) 4 (2.2%)	95 (71.4%) 21 (15.8%) 10 (7.5%) 5 (3.8%) 2 (1.5%)	34 (66.7%) 10 (19.6%) 4 (7.8%) 1 (2.0%) 2 (3.9%)	0.59 0.52 1.0 1.0 0.31	
Clinical Frailty Score	2.0 (2.0, 3.0)	2.0 (2.0, 3.0)	3.0 (2.0, 4.0)	0.06	1
Charlson Comorbidity Index	2.0 (1.0, 3.0)	2.0 (1.0, 3.0)	3.0 (3.0, 4.5)	< 0.01	
Comorbidities, n (%) Asthma Chronic obstructive pulmonary disease Diabetes mellitus Hypertension Ischaemic heart disease Chronic kidney disease Immunosuppression	19 (10.3%) 11 (6.0%) 56 (30.4%) 78 (42.4%) 16 (18.7%) 11 (3.3%) 22 (12.0%)	12 (9.0%) 6 (4.5%) 40 (30.1%) 57 (42.9%) 7 (5.3%) 5 (3.8%) 16 (12.0%)	7 (13.7%) 5 (9.8%) 16 (31.4%) 21 (41.1%) 9 (17.6%) 6 (11.8%) 8 (15.7%)	0.42 0.18 0.86 0.87 0.02 0.07 0.63	
Admission arterial blood gas pH PaO ₂ (kPa) PaCO ₂ (kPa) PaO ₂ /FiO ₂ HCO ₃ ⁻ (mmol/L) Base excess (nmol/L) Lactate (mmol/L)	7.44 (7.38, 7.48) 9.4 (8.5, 11.1) 5.0 (4.5, 5.9) 15.0 (12.1, 19.1) 25.7 (23.2, 28.1) 1.4 (-1.0, 3.6) 1.2 (0.9, 1.6)	7.44 (7.40, 7.48) 9.3 (8.4, 11.5) 5.0 (4.5, 5.7) 15.0 (12.3, 18.9) 25.9 (23.9, 28.2) 1.6 (-0.1, 3.8) 1.1 (0.8, 1.5)	7.43 (7.35, 7.48) 9.6 (8.7, 10.5) 5.0 (4.5, 6.5) 15.4 (12.1, 19.7) 24.9 (20.7, 27.2) 1.2 (-3.2, 2.9) 1.4 (1.0, 1.8)	0.22 0.98 0.58 0.51 0.01 0.03 0.01	Sensitivity
Admission lab variables Bilirubin (μmol/L) Creatinine (μmol/L) Creatinine kinase (IU/L) CRP (mg/L) D-Dimer (μg/L) Ferritin (μg/L) INR LDH (IU/L) Lymphocytes (x10 ⁹ /L) Neutrophil/lymphocyte ratio Procalcitonin (ng/L) Troponin (ng/L)	$\begin{array}{c} 11 \ (8, 14) \\ 73 \ (55, 98) \\ 128 \ (57, 386) \\ 125 \ (67, 192) \\ 619 \ (340, 1283) \\ 687 \ (381, 1168) \\ 1.1 \ (1.0, 1.2) \\ 968 \ (760, 1276) \\ 0.7 \ (0.5, 1.0) \\ 10.5 \ (6.7, 18) \\ 0.3 \ (0.1, 1.0) \\ 15 \ (9, 53) \end{array}$	$\begin{array}{c} 11 \ (7, 15) \\ 68 \ (51, 96) \\ 132 \ (64, 393) \\ 133 \ (77, 192) \\ 614 \ (324, 1148) \\ 656 \ (373, 1093) \\ 1.(1.0, 1.2) \\ 910 \ (755, 1231) \\ 0.7 \ (0.5, 1.0) \\ 10.3 \ (6.1, 17.5) \\ 0.3 \ (0.1, 0.9) \\ 15 \ (8, 37) \end{array}$	$\begin{array}{c} 10 \ (8, 13) \\ 84 \ (66, 106) \\ 99 \ (54, 329) \\ 97 \ (51, 184) \\ 667 \ (358, 2017) \\ 871 \ (543, 1339) \\ 1.(1.0, 1.2) \\ 1098 \ (829, 1431) \\ 0.7 \ (0.5, 0.9) \\ 10.6 \ (6.8, 19.6) \\ 0.3 \ (0.1, 1.0) \\ 20 \ (10, 71) \end{array}$	$\begin{array}{c} 0.93\\ 0.01\\ 0.75\\ 0.29\\ 0.31\\ 0.14\\ 0.25\\ 0.05\\ 0.70\\ 0.58\\ 0.67\\ 0.11\\ \end{array}$	-
ICU severity scores on admission APACHE II SOFA	18.0 (12.0, 23.0) 4.0 (3.0, 7.0)	16.0 (11.0, 23.0) 4.0 (3.0, 6.0)	19.0 (14.3, 24.8) 5.5 (4.0, 8.0)	0.01 0.09	
ICU interventions Pre-intubation NIV/CPAP, n (%) Prone positioning, n (%) Renal replacement therapy, n (%)	113 (61.4%) 147 (79.9%) 50 (27.2%)	93 (69.9%) 109 (82.0%) 30 (22.6%)	32 (62.7%) 38 (74.5%) 20 (39.2%)	0.38 0.30 0.03	
Duration mechanical ventilation (days)	15 (8, 25)	16 (11, 29)	8 (5, 15)	<0.01	
ICU length of stay (days)	20 (11, 36)	24 (17, 42)	11 (6, 17)	<0.01	
Hospital length of stay (days)	28 (19, 53)	41 (27, 64)	16 (10, 20)	< 0.01	

Fig 1. Blood oxygen indices over time between survivors and non-survivors. A. Arterial oxygen content (ml/dL), B. Oxygen extraction ratio (O_2ER), C. PaO_2 (kPa), D. PaO_2 / FiO_2 ratio (kPa)



Fig 2. Blood oxygen indices operating characteristics analysis. A. AUC for FiO₂, PaO₂ and PaO₂/FiO₂, B. Total oxygen content (CaO₂), C. Oxygen extraction ratio (O₂ER)

Table 1. Patient characteristics and outcomes of all patients meeting inclusion criteria (n=184). All scores and laboratory variables were performed at the time of ICU admission. APACHE II: Acute physiology and chronic health evaluation; BMI: Body mass index; CRP: C-Reactive protein; ICU: Intensive care unit; INR: International normalised ratio; LDH: Lactate dehydrogenase; SOFA: Sequential organ failure assessment

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Conclusion

The COVID-19 pandemic offers a unique opportunity to study a homogenous cohort of hypoxic critically unwell patients, with similar underlying pathology. In a cohort of mechanically ventilated adult ICU patients with hypoxic respiratory failure due to COVID-19, oxygen extraction is significantly lower in non-survivors compared to survivors during the first 30 days of ICU admission, despite having higher CaO_2 values. This suggests COVID-19 may cause impaired oxygen utilisation. Urgent further evaluation of the relationship between mitochondrial function and survival in COVID-19 is justified.

References

- 1. COVID-19-associated acute hypoxaemic respiratory failure: experience from a single centre. *British Journal of Anaesthesia*, Elsevier; 2020; 125(4): e368-e371
- 2. ICNARC. ICNARC report on COVID-19 in critical care: England, Wales and Northern Ireland [Internet]. Intensive care national audit & research centre; 2021 Jun Available from: https://www.icnarc.org/Our-Audit/Audits/Cmp/Reports
- 3. Burke H, Freeman A, Dushianthan A, et al. Research Evaluation Alongside Clinical Treatment in COVID-19 (REACT COVID-19): an observational and biobanking study. *BMJ Open* 2021; **11**: e043012