NEUROVASCULAR RESPONSES TO SEQUENTIAL DEEP INSPIRATIONS ASSESSED VIA LASER-DOPPLER PERFUSION CHANGES IN DORSAL FINGER SKIN

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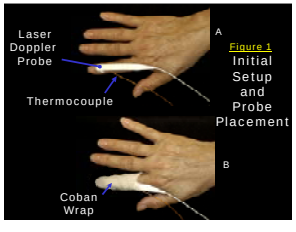
INTRODUCTION

BACKGROUND: A vasomotor reflex that is triggered by a rapid and deep inspiration causes an arteriolar vasoconstriction and induces a transient decrease in skin blood flow. Reports of this phenomena appeared over 50 years ago[1-2], but many details of the sympathetic neural pathways involved are not yet known. Although the reflex causes vasoconstriction, an initial small blood flow increase may precede it and often a flow increase follows (figs 3-4). This inspiratory gasp vascular response (IGVR) has most often been measured on plantar aspects of toes and fingers with laser-Doppler[3-4] or photoplethysmography[5] and has been used to study aspects of neurovascular function in many conditions including diabetes[6], Raynauds phenomena[7],erythromelagia[8] and leprosy[9].

RATIONALE: An important issue related to the use and interpretation of IGVR findings is its variability within the same subject and among subjects. Factors that may affect the magnitude of the vasoconstrictive component include skin temperature, age, gender and vital capacity[4,10] . This variability may represent an intrinsic limit to the utility of the IGVR tests. However, systematic studies of the magnitude of variability and its implications for experimental design & interpretation of findings are sparse. Such variability affects the ability to detect possible differences when comparing normal subjects to patient groups and also affects the ability to detect changes that might be induced by rapidly acting therapeutic interventions in patients with suspected neurovascular deficits.

OBJECTIVES: The present study was undertaken to characterize key features of normal IGVR variability and to explore sampling strategies that might minimize the impact of this variability Specifically, it was our initial objectives to:
(1) Estimate the effect of the number of sequential IGVR samples used to estimate responses of individuals and the variability among subjects
(2) Estimate the extent to which IGVR sample size effects the ability to detect acute changes in IGVR responses that would be associated with acute interventions in individual subjects



METHODS

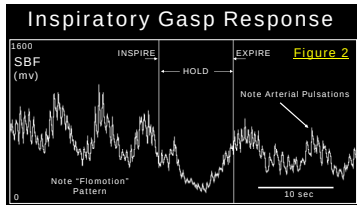
SUBJECTS: Twenty-eight volunteers (14 male) were studied. Subjects had no history of cardiovascular or respiratory abnormality, hypertension or diabetes.

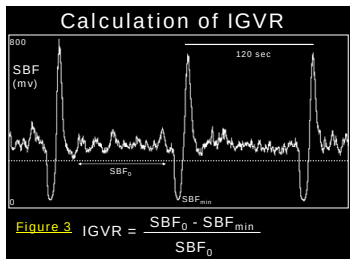
PROCEDURES: Subjects sat in a height adjustable chair with hands placed palm down on a support surface. A laser-Doppler probe was placed on the right index finger dorsum (fig 1A). A small thermocouple was placed under the probe and the finger wrapped with elastic self-adhering bandaging material (fig 1B). The hand was covered with a towel and skin temperature monitored. Testing began when a steady state was reached (15-20 minutes).

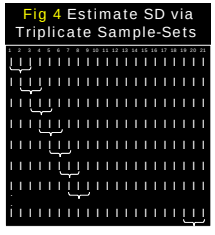
During this interval subjects were instructed as to the required breathing maneuver and were given chances to practice. The instruction was to take a deep and rapid inspiration starting at the end of a normal quiet expiration and hold it for 10 seconds (fig 2).

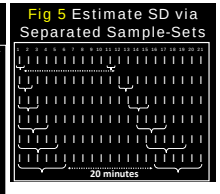
PROTOCOL: The test protocol consisted of a series of 21 sequential inspiratory gasps (IG) taken at two minute intervals. Average finger skin blood perfusion (SBF) during two-minute intervals preceding each successive gasp were used as the reference perfusion for its following inspiratory gasp vascular response (IGVR).
IGVR was calculated using the minimum SBF during the gasp (SBFmin) and the average SBF (SBF0) as shown in fig 3.
Skin and room temperatures were continuously monitored and recorded every two minutes corresponding to each of the inspiratory gasps. After the test, blood pressure was measured and an occlusion (200 mmHg) of the brachial artery for three minutes was used to determine the laser-Doppler biological zero. This value was routinely subtracted from all raw SBF data prior to analyses.

ANALYSES: Dependence of variability among subjects on the number of sequential IG samples used to estimate each persons mean IGVR was determined as shown in fig 4. To estimate the extent to which IG sample-set size affects the ability to detect acute (within subject) changes in IG responses, sample-set sizes of 1, 2, 3, 4, 5 and 6 sequential IGVR were used as shown in fig 5.









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The strategy of FIG 4 has 19 triplicate samples for each of the 28 subjects. Each sample-set yields a separate estimate of mean IGVR for that subject. To estimate an overall SD, the SD of the estimated mean of each sample-set is averaged across subjects and the average of these 19 is used as an estimate of the overall SD of the mean IGVR for the full group. The same approach was used for samples-set sizes of 1, 2, 4, 5, 6 and 10 sequential IG samples.

Effects of IG sample-set size on the ability to detect acute changes were estimated with set sizes of 1-6 IGVR as shown in FIG 5. For each set, SD of differences between 1st & 2nd sets were used. As the goal was to estimate detectible levels of change between "baseline" & an "intervention", 1st sets simulated baselines & sets starting at 10 & 20 minutes afterwards simulated intervention responses. The diagram shows a 20" separation example. For triplicate samples, responses 1-3 are the 1st set & responses 8-10 are the response set an so on up to a sample-set size of six. Correlations between 1st & 2nd sets were also determined. Results were used to estimate a minimum number of subjects needed to detect an IGVR change of either 10 or 20% of the overall mean for a = 0.05 and a power of 90%.

RESULTS

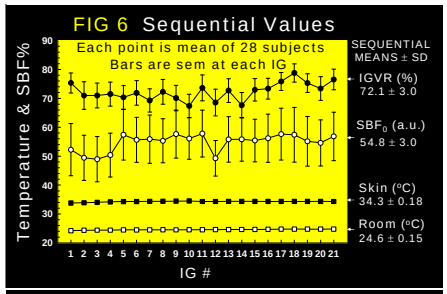
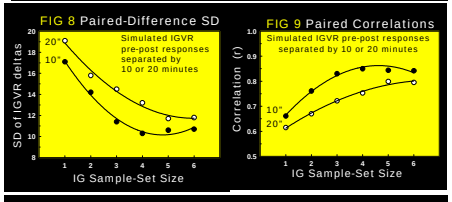
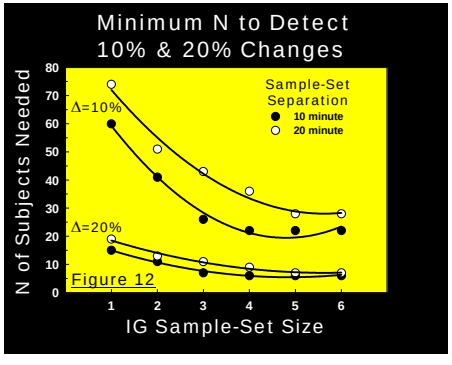


FIG 7 Estimated Min N to Detect 10% and 20% changes in IGVR

IG Set Size	SD and Correlation of paired-differences: 10 minutes SD	10 minutes R	20 minutes SD	20 minutes R	Minimum Required Subjects*: 10 % change 10 min	10 % change 20 min	20% change 10 min	20% change 20 min
1	17.1	0.661	19.1	0.615	60	74	15	19
2	14.2	0.761	15.8	0.670	41	51	11	13
3	11.4	0.830	14.5	0.722	26	43	7	11
4	10.3	0.859	13.2	0.753	22	36	6	9
5	10.6	0.844	11.7	0.799	22	28	6	7
6	10.7	0.842	11.8	0.795	22	28	6	7

**Tabulated values of N are for an a of 0.05 and power of 90%*





CONCLUSIONS

1. In this group of 28 healthy subjects the overall mean perfusion decrease induced by 21 sequential inspiratory gasps and measured at the finger dorsum was 72% of each responses immediately preceding two-minute baseline blood perfusion.
2. This magnitude of IGVR is comparable to values reported for those obtained at finger palmer surface that is rich in arterial-venous anastamoses (AVAs). This suggests that the magnitude of the IGVR is not fully dependent on AVA presence.
3. Variability of IGVR, within and across subjects, depends on the N of sequential sample-sets used in the estimation of IGVR and on the time separation between sample-sets for within subject measures.
4. The ability to statistically detect differences in IGVR between normals and patients with suspected neurovascular deficits thus depends on the number of IGVR samples used to characterize the mean response and on the number of subjects N.
5. Similarly, the ability to detect acute changes in IGVR, potentially associated with effects of rapidly acting therapeutic interventions that modify IGVR, depends on the IG sample-set size, the correlation between time separated sample-sets and on N.
6. The analyses provide a framework for, and specific estimates of, the minimum N needed to detect specified IGVR differences between groups or changes in IGVR after such interventions.
7. Applying these findings to results reported in the literature suggests that some previously drawn conclusions lack suitable statistical underpinnings.

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