Original Article

Assessment of sedation level in critically ill mechanically ventilated patients: Is bispectral index correlated with Richmond agitation–sedation scale?

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Abstract

BACKGROUND: The intensivist should be avoided over or under sedation in mechanically ventilated patients. There are controversies in validity of bispectral index (BIS) in the management of intensive care unit (ICU) patients. The aim of this study was to evaluate sedation level in sedated and mechanically ventilated patients in our ICU using BIS and Richmond agitation–sedation scale (RASS, as a valid tool) and to determine the correlation between these two methods of evaluation.

METHODS: Following the institutional research committee approval, we prospectively determined the sedation level in 33 patients aged 20-75 years who were mechanically ventilated and sedated routinely using intravenous diazepam (0.05 – 0.1 mg/kg/6 hr) combined with intravenous morphine (0.05 – 0.1 mg/kg/6 hr) in central ICU of Al-Zahra hospital. In each patient, we assessed BIS (0 to 100) values and also RASS (-5 to +4) twice a day, two hours after receiving systemic sedation in the morning and evening during mechanical ventilation period. Appropriate sedation score was considered -2 and -3 on RASS and 70 to 80 in BIS. Lower or greater values were considered as under- or over-sedation, respectively. Data were analyzed using chi-square and spearman's correlation tests.

RESULTS: In this study, sedation level was assessed in patients using RASS (201 times) and BIS (201 times) methods. The frequency (percent) of under-sedated, appropriately sedated and over-sedated patients with BIS assessments were 121 (60.2%), 35 (17.4%) and 45 (22.4%), respectively. These values for RASS assessments were 196 (97.5%), zero, and 5 (2.5%), respectively. There was a weak correlation between BIS and RASS for determination of sedation level (P = 0, r = 0.245).

CONCLUSIONS: This study showed that most of our ICU patients were under-sedated. BIS was poorly correlated with RASS in assessing the depth of sedation in mechanically ventilated patients.

KEYWORDS: Richmond agitation–sedation scale, sedation, bispectral index, ICU, mechanical ventilation.
favour life-threatening events such as accidental extubation. The monitoring of the desired level of sedation will help avoidance of over- and under-sedation and may ultimately improve the outcome of the patients. Various scales to assess level of sedation in critically ill patients have been developed including: Ramsay sedation scale, Richmond agitation-sedation scale (RASS), sedation agitation scale (SAS), Cook scale, modified GCS and alertness sedation scale. The reliability of bispectral index (BIS) as an electroencephalographic device for assessment of sedation level in critically ill mechanically ventilated patients was confirmed in some studies. Inversely, one study showed that BIS was not a valuable tool for assessment of sedation level in these patients. BIS is a valid measure of wakefulness after cardiac surgery but electromyogram (EMG) interference may affect the accuracy of BIS for small percentage of patients not receiving neuromuscular blockade. RASS has been proved to be a useful, reliable and valid bedside tool in the management of sedation in ventilated and non-ventilated adult ICU patients. Recently, Turkmen et al studied the correlation between the RASS and BIS during dexmedetomidine sedation. They concluded that RASS levels significantly correlated with BIS values during dexmedetomidine sedation in critically ill patients requiring mechanical ventilation in ICU. The aim of this study was to assess sedation level in our central ICU patients under MV using RASS (as a valid tool) and to determine its correlation with BIS (as a trial tool) in these patients.

Methods
Following ethics committee approval, in this cross-sectional study we determined the sedation level in 33 patients aged 20 to 75 years who were mechanically ventilated and sedated routinely in central ICU of Al-Zahra medical center. The exclusion criteria were as follow: need to MV less than 24 hours, full support MV, administration of muscle relaxants, history of visual, auditory, musculoskeletal and CNS disturbances, drug abuse and addiction. In each patient we assessed BIS values and also RASS twice a day at times two hours after receiving systemic sedation. Routine systemic sedation was performed using intravenous morphine (0.05 - 0.1 mg/kg/6 hr) and diazepam (0.05 - 0.1 mg/kg/6 hr) based on intensivist clinical judgment. Patients were received both drugs at 8 am and 2 pm and sedation scores were assessed and recorded at 10 am and 4 pm using BIS and RASS till weaning the patients from mechanical ventilation. The BIS and RASS were measured alternatively by 15 minutes intervals for each recording; for example, if the sedation level was first assessed by RASS, the next recording would begin by BIS assessment. After wiping the skin by alcohol, the BIS sensor probe was placed on the patient's forehead and was connected to the BIS monitor (model A-2000, XP platform; Aspect Medical Systems, USA) and impedance test was confirmed. Data were collected by a nurse who was not directly involved in patients care. The BIS is a numeric value from zero (deep sedation) to 100 (awake) derived from complex mathematical analysis of the electroencephalogram. The RASS use a 10 point scale from -5 (unarousable) to +4 (combative) (table 1). Appropriate sedation score was considered -2 and -3 on RASS and 70 to 80 on BIS. Lower or greater values were considered as under- or over-sedation, respectively. Data were analyzed using chi-square test, and Spearman and Pierson correlations. Values for quantitative variables were reported as mean± standard deviation, and for qualitative variables as count and percent. For all tests, statistical significance was assumed if P<0.05. SPSS version 12 was used for statistical analysis.

Results
In this cross-sectional study, sedation level was assessed in 33 mechanically ventilated patients using RASS (201 times) and BIS (201 times) till weaning the patients from ventilator in ICU. None of the patients were excluded from the study. The mean age of patients was 51.27 ± 19.38 years and the female to male ratio was 14/19. The two most common underling prob-
lems were thoracotomy (n = 11, 32%) and cardiopulmonary bypass (n = 5, 14%). The other underlying problems were included systemic lupus erythematosus, myasthenia gravis, laparotomy, gun shot injury, pancreatitis, diabetes mellitus, lung contusion, ascitis, hyperparathyroidism, gastrointestinal bleeding, blunt trauma, core pulmonale, peritoneal mass and pheochromocytoma. The frequency distribution of sedation scores in two methods of assessment is shown in table 1 and figure 1. According to table 1 and figure 1, there was a significant difference between RASS and BIS in frequency distribution of sedation scores (P = 0), and there was a weak correlation between RASS and BIS too (P = 0, r = 0.136). The frequencies of appropriate, over- and under-sedation levels in the two methods of assessment are presented in table 2. This table shows that there was a weak correlation between data reported from BIS and RASS according to the sedation level.

### Table 1. The frequency of distributions of sedation scores using RASS and BIS.

<table>
<thead>
<tr>
<th>RASS Score</th>
<th>RASS N (%)</th>
<th>BIS Score</th>
<th>BIS N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>-5</td>
<td>3 (1.5)</td>
<td>0-9</td>
<td>0</td>
</tr>
<tr>
<td>-4</td>
<td>2 (1)</td>
<td>10-19</td>
<td>0</td>
</tr>
<tr>
<td>-3</td>
<td>0</td>
<td>20-29</td>
<td>0</td>
</tr>
<tr>
<td>-2</td>
<td>0</td>
<td>30-39</td>
<td>2 (1)</td>
</tr>
<tr>
<td>-1</td>
<td>1 (0.5)</td>
<td>40-49</td>
<td>9 (4.5)</td>
</tr>
<tr>
<td>0</td>
<td>82 (40.6)</td>
<td>50-59</td>
<td>9 (4.5)</td>
</tr>
<tr>
<td>+1</td>
<td>102 (51)</td>
<td>60-69</td>
<td>25 (12.4)</td>
</tr>
<tr>
<td>+2</td>
<td>7 (3.5)</td>
<td>70-79</td>
<td>35 (17.4)</td>
</tr>
<tr>
<td>+3</td>
<td>4 (2)</td>
<td>80-89</td>
<td>67 (33.8)</td>
</tr>
<tr>
<td>+4</td>
<td>0</td>
<td>90-100</td>
<td>53 (26.4)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>201 (100)</td>
<td><strong>Total</strong></td>
<td>201 (100)</td>
</tr>
</tbody>
</table>

P = 0.000 (chi-square), r = 0.136 (Spearman correlation).

![Figure 1. Scatter graph of distribution of sedation scores in RASS and BIS.](https://www.mui.ac.ir)
### Table 2. The frequency of appropriate, over- and under-sedation levels in RASS and BIS (N, %).

<table>
<thead>
<tr>
<th>RASS</th>
<th>BIS Over-sedation</th>
<th>Appropriate sedation</th>
<th>Under-sedation</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over sedation</td>
<td>5 (100)</td>
<td>0</td>
<td>0</td>
<td>5 (100)</td>
</tr>
<tr>
<td>Appropriation sedation</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Under sedation</td>
<td>40 (20.4)</td>
<td>35 (17.9)</td>
<td>121 (61.7)</td>
<td>196 (100)</td>
</tr>
<tr>
<td>Total</td>
<td>45 (22.4)</td>
<td>35 (17.4)</td>
<td>121 (60.2)</td>
<td>201 (100)</td>
</tr>
</tbody>
</table>

P = 0.001 (chi-square), r=0.245 (Pierson correlation).

### Discussion

The current study demonstrated that the sedation level in mechanically ventilated patients in our ICU was mostly inappropriate and the patients were commonly under-sedated. Pronovost and co-workers showed that the median percentage of days in which mechanically ventilated patients received appropriate sedation was 64%. Therefore, they stated that in order to improve quality of care, we must measure our performance. By improving performance on these measures, we may reduce mortality, morbidity and, duration of ICU stay. Providing an optimal level of sedation is an important part of the management of mechanically ventilated, critically ill patients. Given these facts, revision of pharmacological sedation protocols should be considered in our ICU. In this study, data extracted from BIS and RASS tools showed a poor correlation between the two methods of sedation assessment. Our results are comparable with the findings of De Deyne et al that critical illness itself may alter the BIS and that target BIS values may differ between anesthesia and critical care-based applications. The correlation between clinical assessment and BIS for determination of sedation level in critically ill patients is controversial. Some authors believed that BIS is a useful tool for assessment of patients' sedation. Frenzel et al evaluated the validity of BIS on 19 mechanically ventilated patients and concluded that BIS is not suitable for monitoring sedation in this heterogeneous group of surgical ICU patients. A recent study reported a good correlation between BIS and SAS in assessing the depth of sedation in patients under MV and sedated using propofol infusion. The difference between the results of the present study and the above-mentioned report may be due to application of different clinical assessments of patients sedation. Our study compared RASS with BIS, but the above-mentioned study reported comparison between SAS and BIS. There are some studies that do not confirm our results. However, interpreting the literature on the usefulness of the BIS as an electronic tool for patients sedation evaluation in the ICU is difficult for some reasons including heterogeneous population, different methods of collecting BIS data, and use of different versions of BIS software and hardware. Unavailability for more frequent measurements of BIS and RASS during each day was the major limitation of our study.

### Conclusions

This study demonstrated that most of our central ICU patients were under-sedated. BIS was poorly correlated with RASS in assessing the depth of sedation in mechanically ventilated patients. More studies should be done in this regard on similar patients.
References


