CHAPTER 3

Quality of donor lung grafts: a comparative study between explosive and gradual brain death induction models in rats

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In preparation
ABSTRACT

Introduction

Despite the fact that brain death induces pro-inflammatory changes, correlating with the reduction of graft quality and outcome after transplantation, brain dead donors are the major source for transplantation. This study is designed to test whether explosive or gradual increase in intracranial pressure, to induce brain death, have a differential effect on the graft quality, and to identify deleterious mechanisms during brain death.

Materials and methods

Fisher (F344) rats were randomly assigned into three donor groups: 1) no intervention and immediate sacriﬁcence, 2) explosive - and 3) gradual brain death induction model. The latter were subdivided in sacriﬁcence time points 1, 2 and 4 hrs. after brain death induction. During the brain death period the animals were hemodynamically stabilized and lung protective ventilated. Hemodynamic changes and pulmonary inspiratory pressure were monitored, the lungs were analyzed with a histological scoring system and for pro-inﬂammatory changes in gene expression with polymerase chain reaction.

Results

Immediately after explosive traumatic brain death induction 6 rats were lost, developing severe lung edema and subsequent failure of ventilation compared to none in the gradual model. Remarkable was the difference in mean arterial pressure before onset of brain death, followed by a considerably higher need of inotropic support in the explosive brain death model. In both groups patho-histological changes were found, but in the explosive model parenchyma injury was already pronounced immediately after conﬁrmation of brain death as a result of a more pronounced edema formation in the explosive model. The over time increasing pro-inﬂammatory changes in gene expression were not substantially different between the models, with the exception of the Vcam1 gene expression that was more pronounced in the gradual model.

Conclusion

The results of this study suggest that donor lungs suffer more injury after explosive onset of brain death, possibly making them unsuitable for transplantation, compared to gradually injured. However, ﬁndings in gene expression lead us to conclude that if lungs are considered suitable for transplantation the outcome after transplantation should be independent of the etiology of brain death.

INTRODUCTION

Lung transplantations are commonly performed using lungs derived from brain dead organ donors, who died of an extensive central nervous system injury secondary to an event of trauma, hemorrhage or infarction. At onset of brain death series of detrimental processes is initiated as a result of increased intracranial pressure. Initially, a massive increase of catecholamines in the blood occurs, also known as autonomic storm, this is accompanied by a signiﬁcant increase in systemic vascular resistance (SVR)1-4. The sudden increase in systemic vascular resistance results in the pooling of a large proportion of the total blood volume in the cardio pulmonary vasculature. Shortly after the autonomic storm the SVR decreases again and the aortic blood ﬂow either normalizes or in most of the subjects even results in hypotension5.

Along with the hemodynamic changes brain death initiates an immune response in the peripheral organs6. Brain death related changes have been identiﬁed as underlying reason for inferior outcome after lung transplantation7. The lung seems to be more susceptible to brain death induced injury than other organ systems because from reported brain dead donors 90% of the kidneys and 70% of the livers were procured for transplantation in contrast to only 20% of the lungs in 20078. Lungs are selected dependent on their quality9. Reduced graft quality is the result of both, the early hemodynamic changes and the pro-inflammatory immune response which are also linked to the formation of pulmonary edema and increased pulmonary capillary leakage10-12. Nevertheless, more pronounced hemodynamic and hormonal changes have been described for the explosive brain death model13-14. As a consequence of the more pronounced alterations in the explosive model ischemic injury in the donor hearts is more severe, explaining the inferior outcome after transplantation14. The hemodynamic changes in the explosive model have been suggested to impact the graft quality before as well as after transplantation15-16. In difference to other organ systems clinical data are not conclusive whether cause of brain death affects lung transplantation outcome17-19. We investigated in an animal experiment if the etiology of brain death affects the quality of the donor lung graft and whether this is due to differences in hemodynamics, immune response or both.

MATERIALS AND METHODS

Animals

All rats were kept under clean conventional conditions, with a 12/12h light-dark cycle at 22°C and were fed standard rat chow ad libitum. All animals received humane care in compliance with the Principles of Laboratory Animal Care (NIH Publication No.86-23, revised 1985) and the Dutch Law on Experimental Animal Care. The experiments were approved by the local animal care committee.

Experimental groups

Fisher (F344) rats weighing 270-300g at the time of experiment were obtained from Harlan, Netherlands. In total seventy-two (excluding 6 animals lost after BD induction) rats were randomly assigned into three groups: 1) no intervention (control), 2) explosive (1 minute) or 3) gradual (30 minutes) brain death induction model. Animals in group 2 and 3 were sacrificed at four different time points: 30 minutes, 1 hour, 2 hours and 4 hours after onset of brain death.

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The results of this study suggest that donor lungs suffer more injury after explosive onset of brain death, possibly making them unsuitable for transplantation, compared to gradually injured. However, findings in gene expression lead us to conclude that if lungs are considered suitable for transplantation the outcome after transplantation should be independent of the etiology of brain death.

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Brain death model

Anaesthesia was induced with oxygen (1 l/min) / isoflurane 5% and reduced to oxygen/ isoflurane 2% for continuation. Subcutaneously 2 ml of saline were administered before the start of surgery. Animals were tracheotomized in supine position, intubated with a 14G polyethylene tube and mechanically volume controlled ventilated with a Harvard apparatus (model 683). The ventilation was set at a tidal volume of 6.5 ml/kg of body weight (BW), PEEP of 3 cmH2O and fraction of inspired oxygen (FO2) of 0.4 until the end of brain death induction when it was reduced to 0.5. The respiratory frequency was initially set at 120/min and was throughout the experiment adjusted as needed to keep the ETCO2 between 20-22 mmHg.

The left femoral artery was cannulated and used for continuous monitoring of mean arterial pressure (MAP), while the left femoral vein was cannulated and used to stabilize the MAP above 80 mmHg by fluid bolus (with a maximum of 1 ml per hour) of colloidal solution (HAES- steril 10%, Fresenius Kabi, Bad Homburg, Germany) and infusions of norepinephrin (0.01 mg/ml) as needed with a perfusor.

In all experimental groups, a fronto-lateral burr hole was drilled with a microdrill at 10,000 rpm with the boring head 990S (Dremel, Breda, Netherlands) and a 4F Fogarty catheter (Edwards Lifesciences LLC, Irvine, U.S.A.) inserted. Brain death was induced with ≤ 0.5 ml distilled water by infusion and expansion of the 4F Fogarty catheter with a syringe perfusor pump (Terufusion Syringe Pump, model STC-521). For the explosive model the fogarty catheter was expanded in 60 sec., for the gradual model in 30 min. To reduce muscle movements during BD induction 0.6 mg/kg of bodyweight rocuronium was given. At the end of the observation period 0.1 mg/kg of BW succinylcholine was given i.v. just prior to organ harvest to prevent movement due to spinal reflexes. After this a laparo- and thoracotomy was performed and the aorta was punctured to withdraw blood for plasma analysis, the circulatory system was subsequently flushed with 40 ml of cold saline after flushing the lung with 4% of formalin fixing with 4% of formalin. Lungs were subsequently stained with haematoxylin-eosin. A five-point semiquantitative severity-based scoring system was used as previously described21. The pathological findings were graded as negative = 0, slight = 1, moderate = 2, high = 3, and severe = 4. The amount of intra- and extra-alveolar haemorrhage, intra-alveolar edema, inflammatory infiltration of the interalveolar septa and airspace and overinflation were rated. Deviating from the original scoring scheme erythrocyte accumulation below the pleura was scored as 1 =...
present or 0 = not present. The scoring variables were added and a histological total lung injury score per slide was calculated after morphological examination was performed simultaneously by two blinded investigators. For this a conventional light microscope was used at a magnification of 200 across 10 random, non-coincidental microscopic fields.

**Plasma analysis**

The collected blood was immediately placed into EDTA-tubes after harvest and centrifuged at 10,000 rpm at 4°C. Supernatant was transferred into sterile Eppendorf tubes and stored until further use at –80°C. Analysis for troponin and CK-MB were performed in the clinical laboratory.

**Statistical Analysis**

A two-way ANOVA was conducted to examine the effects of brain death model and time on physiological parameters, wet-dry-ratio, RTD- PCR, histological scoring, total volume administration, NA, CK-MB and Troponin. Outliers were assessed by inspection of the boxplot. Normality of the data distributions were visually inspected using probability-probability plot (P-P plot). Not normally distributed data were transformed by the natural logarithm. To correct zero values in total volume administration and histological scoring 0.1 was added before performing the natural logarithm. Mean arterial pressure during brain death induction and after 4hrs of brain death therefore a Mann-Whitney test was used to determine differences between brain death models. The MAP was not normally distributed at end of brain death induction model, expansion of the fogarty catheter over a period of 30 min. with a pump; HR– heart rate (beats/min.); MAP– mean arterial pressure; Paw– pulmonary airway pressure; RTD- PCR– real-time quantitative polymerase chain reaction.

The mean arterial pressure in the explosive model was significantly higher during twenty minutes before end of brain death induction compared to the gradual model. During the initial phase of hemodynamic stabilization was the MAP higher in the explosive model, while there was no difference between groups after four hours of stabilization (Figure 1). In contrast to this the need of total volume administration in the explosive model was higher compared to the gradual model (1.2 ± 1.1 ml (EM) vs. 0.6 ± 0.5 ml (GM); p < 0.05). Nevertheless, there were no relevant differences in Wet-Dry ratio between the groups including the control group.

**RESULTS**

**Failure of hemodynamic stabilization**

Fisher rats (F344) were randomly assigned to control or the brain death models with subgroups of different stabilization periods. In the explosive brain death arm 6 animals were lost immediately after the induction of brain death since ventilation was not feasible (excluded from analysis and replaced), while no animal was lost in the gradual brain death model. At dissection of the thoracic cavity in 5 out of 6 animals a fulminant lung edema (excluded from analysis and replaced), while no animal was lost in the gradual brain death model. Analysis for troponin and CK-MB were performed in the clinical laboratory.

**Physiological data**

Of the three groups, only the two brain death groups were ventilated and stabilized during which time physiological data were collected. The parameters pulmonary inspiratory pressure, heart rate and mean arterial pressure of each brain death model were taken together as available for the given time points and analyzed (Table 2). There was no difference in pulmonary inspiratory pressure between the models but the heart rate was elevated in the explosive brain death model.

| Table 2. Physiological parameters selected in the brain dead donor groups. |
|-----------------------------|------------------|
|                             | BL               |
|                             | BD 0.5h          |
|                             | BD 1h            |
|                             | BD 2h            |
|                             | BD 4h            |
|                             | EM   | GM   | EM   | GM   | EM   | GM   | EM   | GM   |
| Paw (cmH$_{2}$O)            | 8 ± 1 | 9 ± 1 | 9 ± 1 | 9 ± 1 | 9 ± 1 | 9 ± 1 | 10 ± 2 | 9 ± 2 |
| HR (beats/min.)             | 345 ± 426 ± 425 ± 375 ± 415 ± 375 ± 387 ± 385 ± 10 ± 2 |
| MAP (mmHg)                  | 348 ± 345 ± 342 ± 340 ± 375 ± 375 ± 387 ± 385 ± 10 ± 2 |

The given values are presented as mean ± standard error of the mean.

**Figure 1.** Mean arterial pressure overtime. Expansion of the Fogarty catheter and induction of brain death was finished at time point zero in both models. After end of brain death induction all animals were stabilized above a mean arterial pressure of 80 mmHg. The presented mean arterial pressure data are depicted as mean.
The time of brain death induction does not influence the investigated proinflammatory gene expression during 4 hrs. of brain death

In both brain death models the pro-inflammatory cytokine gene expression of Tnf and Il6 was induced, but levels did not reach significance between the two models. Gene expression of the Il8-like Cinc1 was unaffected by groups and time. For Mcp1 and Vcam1 an increase in a quadratic regression was noted over time with the time centered at 1.5 hrs. For Gapdh a trend towards significance (p < 0.053) was found between groups for that reason different housekeeping genes were chosen for further analysis (Table 3).

**Table 3.** Changes in pro-inflammatory cytokine gene expression after different durations of brain death.

<table>
<thead>
<tr>
<th>RTD-PCR</th>
<th>Control BD 0.5h</th>
<th>EM BD 1h</th>
<th>GM BD 1h</th>
<th>Control BD 2h</th>
<th>EM BD 2h</th>
<th>GM BD 2h</th>
<th>Control BD 4h</th>
<th>EM BD 4h</th>
<th>GM BD 4h</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tnf</td>
<td>0.02 ± 0.02</td>
<td>0.60 ± 0.1</td>
<td>0.73 ± 0.2</td>
<td>0.91 ± 0.1</td>
<td>0.75 ± 0.5</td>
<td>0.88 ± 0.3</td>
<td>1.39 ± 0.5</td>
<td>1.52 ± 0.5</td>
<td></td>
</tr>
<tr>
<td>Il6</td>
<td>0.01 ± 0.02</td>
<td>0.36 ± 0.1</td>
<td>0.40 ± 0.2</td>
<td>0.32 ± 0.1</td>
<td>0.32 ± 0.2</td>
<td>0.34 ± 0.1</td>
<td>0.65 ± 0.3</td>
<td>0.80 ± 0.6</td>
<td></td>
</tr>
<tr>
<td>Cinc1</td>
<td>0.03 ± 0.02</td>
<td>0.14 ± 0.1</td>
<td>0.19 ± 0.2</td>
<td>0.13 ± 0.1</td>
<td>0.12 ± 0.2</td>
<td>0.14 ± 0.1</td>
<td>0.13 ± 0.2</td>
<td>0.13 ± 0.4</td>
<td></td>
</tr>
<tr>
<td>Mcp1</td>
<td>0.02 ± 0.02</td>
<td>0.07 ± 0.1</td>
<td>0.10 ± 0.2</td>
<td>0.05 ± 0.1</td>
<td>0.12 ± 0.2</td>
<td>0.12 ± 0.1</td>
<td>0.36 ± 0.3</td>
<td>0.56 ± 0.3</td>
<td></td>
</tr>
<tr>
<td>Vcam1</td>
<td>0.14 ± 0.04</td>
<td>0.76 ± 0.3</td>
<td>1.26 ± 0.3</td>
<td>0.48 ± 0.2</td>
<td>0.72 ± 0.2</td>
<td>0.89 ± 0.2</td>
<td>0.46 ± 0.3</td>
<td>0.34 ± 0.4</td>
<td></td>
</tr>
<tr>
<td>GAPDH</td>
<td>0.02 ± 0.02</td>
<td>0.07 ± 0.1</td>
<td>0.10 ± 0.2</td>
<td>0.05 ± 0.1</td>
<td>0.12 ± 0.2</td>
<td>0.12 ± 0.1</td>
<td>0.36 ± 0.3</td>
<td>0.56 ± 0.3</td>
<td></td>
</tr>
</tbody>
</table>

- Control: immediately sacrificed without intervention; BD: brain death induction model; 0.5h: 30 minutes of donor management; 1/2/4- hours of donor stabilization; 1/2/4- hours of donor management
- BD 0.5h–4h–: brain dead group with period of ventilation and circulatory stabilization time; Control– immediately sacrificed without intervention; Cinc1– chemokine (C-C motif) ligand 2; Il6– interleukin 6; RTD-PCR– real-time detection PCR; Tnf– tumor necrosis factor; Vcam1– vascular adhesion molecule 1

Explosive brain death induction results in more severe lung injury then gradual brain death induction on a histological level

Total lung injury score was higher in the explosive brain death model than in the gradual brain death model, as well as changes are significant over time. This is the result of a more pronounced hemorrhagic infarcted lung tissue, edema and pleural infarction in the explosive model compared to the gradual brain death model (Figure 2 + Table 4).

**Table 4.** Histological lung injury score.

<table>
<thead>
<tr>
<th>Histological Score</th>
<th>Control BD 0.5h</th>
<th>Control BD 1h</th>
<th>Control BD 2h</th>
<th>Control BD 4h</th>
<th>EM BD 0.5h</th>
<th>EM BD 1h</th>
<th>EM BD 2h</th>
<th>EM BD 4h</th>
<th>GM BD 0.5h</th>
<th>GM BD 1h</th>
<th>GM BD 2h</th>
<th>GM BD 4h</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemorrhage</td>
<td>0.2 ± 0.1</td>
<td>0.3 ± 0.1</td>
<td>0.4 ± 0.1</td>
<td>0.5 ± 0.1</td>
<td>0.6 ± 0.1</td>
<td>0.7 ± 0.1</td>
<td>0.8 ± 0.1</td>
<td>0.9 ± 0.1</td>
<td>1.0 ± 0.1</td>
<td>1.1 ± 0.1</td>
<td>1.2 ± 0.1</td>
<td>1.3 ± 0.1</td>
</tr>
<tr>
<td>Edema</td>
<td>0.0 ± 0.0</td>
<td>0.1 ± 0.1</td>
<td>0.2 ± 0.1</td>
<td>0.3 ± 0.1</td>
<td>0.4 ± 0.1</td>
<td>0.5 ± 0.1</td>
<td>0.6 ± 0.1</td>
<td>0.7 ± 0.1</td>
<td>0.8 ± 0.1</td>
<td>0.9 ± 0.1</td>
<td>1.0 ± 0.1</td>
<td>1.1 ± 0.1</td>
</tr>
<tr>
<td>Inflammation</td>
<td>1.0 ± 0.0</td>
<td>1.1 ± 0.0</td>
<td>1.2 ± 0.0</td>
<td>1.3 ± 0.0</td>
<td>1.4 ± 0.0</td>
<td>1.5 ± 0.0</td>
<td>1.6 ± 0.0</td>
<td>1.7 ± 0.0</td>
<td>1.8 ± 0.0</td>
<td>1.9 ± 0.0</td>
<td>2.0 ± 0.0</td>
<td>2.1 ± 0.0</td>
</tr>
<tr>
<td>Over-inflation</td>
<td>0.0 ± 0.0</td>
<td>0.1 ± 0.1</td>
<td>0.2 ± 0.1</td>
<td>0.3 ± 0.1</td>
<td>0.4 ± 0.1</td>
<td>0.5 ± 0.1</td>
<td>0.6 ± 0.1</td>
<td>0.7 ± 0.1</td>
<td>0.8 ± 0.1</td>
<td>0.9 ± 0.1</td>
<td>1.0 ± 0.1</td>
<td>1.1 ± 0.1</td>
</tr>
<tr>
<td>Pleura Infarction</td>
<td>0.0 ± 0.0</td>
<td>0.1 ± 0.1</td>
<td>0.2 ± 0.1</td>
<td>0.3 ± 0.1</td>
<td>0.4 ± 0.1</td>
<td>0.5 ± 0.1</td>
<td>0.6 ± 0.1</td>
<td>0.7 ± 0.1</td>
<td>0.8 ± 0.1</td>
<td>0.9 ± 0.1</td>
<td>1.0 ± 0.1</td>
<td>1.1 ± 0.1</td>
</tr>
<tr>
<td>Total</td>
<td>2.0 ± 0.0</td>
<td>2.1 ± 0.1</td>
<td>2.2 ± 0.1</td>
<td>2.3 ± 0.1</td>
<td>2.4 ± 0.1</td>
<td>2.5 ± 0.1</td>
<td>2.6 ± 0.1</td>
<td>2.7 ± 0.1</td>
<td>2.8 ± 0.1</td>
<td>2.9 ± 0.1</td>
<td>3.0 ± 0.1</td>
<td>3.1 ± 0.1</td>
</tr>
</tbody>
</table>

The values presented are mean ± standard deviation (SD).
Need of inotropic support and release of heart injury markers are more pronounced in the explosive model

To ensure sufficient oxygenation of the solid organs, brain dead donors are stabilized at a mean arterial pressure above 80 mmHg, for this inotropic substances are being used in the clinic. We chose to give 0.01 mg/ ml noradrenalin (NA) as needed with a perfusor. There was a distinct difference between the two models, the need of NA was higher in the explosive model compared to the gradual model (p < 0.005).

Both, brain death and inotropic support may have substantial effect on the heart and subsequently on the lung. For that reason, we analyzed two sensitive markers for heart injury- CK-MB and troponin. The release of CK-MB into the plasma was higher in the explosive model compared to the gradual model, however did not change over time. Correlating to the CK-MB levels did the troponin levels differ between the groups. However, there was also a respective increase over time (Table 5).

**DISCUSSION**

This is to our knowledge, the first investigation comparing the effect of explosive and gradual brain death induction models on lung graft quality over different time periods in rats. Both models resulted in the decrease of graft quality over time, however more pronounced in the explosive brain death induction model during the initial phase. This difference was observed in higher mortality, increase of pulmonary inspiratory pressure, more need of hemodynamic support and pronounced patho-histological changes. In contrast to this no differences were found in the investigated proinflammatory gene expression.

Since in kidney and heart transplantation the cause of brain death seems to have a substantial influence on the early outcome after transplantation, a number of studies have investigated the effect of cause of brain death in lung transplantation. While they failed to show a correlation between cause of brain death and outcome, it was noted that donors with traumatic brain injury had a higher incidence in severity of rejection episodes though this had no effect on the survival. However, these studies did not analyse whether the cause of brain death affects the availability of donor organs.

In a comparative study, with emphasis on the heart, it has been shown that the two brain death induction models differ in the development of mean arterial pressure during brain death induction. The acute increase in mean arterial pressure in the explosive brain death induction model is compared to a more tempered development in the gradual model, and is considered to be the result of a more pronounced sympathetic discharge, followed by a more profound hypotension. Sudden increase in mean arterial pressure causes the rupture of the capillary-alveolar membrane and disruption of the barrier integrity. Preventing the hypertensive response to explosive brain death induction limited the inflammatory immune response and prevented changes in capillary-alveolar membrane integrity. This could explain, why acute cerebral insult and brain death have been associated with the onset of pulmonary edema, while it is rare in subarachnoid hemorrhage, which causes a gradual increase of intracranial pressure. Additionally, the loss of capillary integrity is accompanied by hemorrhage. The hemodynamic pattern during the initial phase between our two brain death induction models respectively differs and may explain the difference we found in loss of animals during the initial phase after brain death induction. After the induction phase the mean arterial pressure was stabilized in our set up by utilization of HAES and noradrenalin. Administration of exogenous noradrenalin has been associated with graft deterioration in other solid organ systems, however in the lung the prevention of hypotensive collapse using noradrenalin correlated with reduced edema and inflammation. In this setting intrinsic catecholamine levels up on brain death induction were not determined nor histological myocardial changes. However it is expected that the increase in troponin and CK-MB are the results of more pronounced intrinsic catecholamine release.

While there seems to be a correlation between hemodynamic changes and the inflammatory immune response during brain death, it is not the only reason for the inflammatory immune response found in brain dead donor lungs. Exposing living controls to blood withdrawn from brain dead donors in the absence of hemodynamic changes causes an inflammatory response. The origin of this systemic inflammation has not been identified yet.

In conclusion, the results of this study suggest that donor lungs suffer more morphological injury after explosive onset of brain death. As a consequence, less lungs from donors with acute onset of brain death might be considered suitable for lung transplantation however this has not been investigated in this study, nor to our knowledge clinically. However, findings in gene expression lead us to conclude that the outcome after transplantation should be independent of the etiology of brain death.

<table>
<thead>
<tr>
<th>Table 5. Administered total inotropic support during donor management and heart muscle injury markers</th>
<th>Control</th>
<th>EM</th>
<th>GM</th>
<th>Control</th>
<th>EM</th>
<th>GM</th>
<th>Control</th>
<th>EM</th>
<th>GM</th>
</tr>
</thead>
<tbody>
<tr>
<td>BD 0.5h</td>
<td>n = 8</td>
<td>n = 8</td>
<td>n = 8</td>
<td>n = 8</td>
<td>n = 8</td>
<td>n = 8</td>
<td>n = 8</td>
<td>n = 8</td>
<td>n = 8</td>
</tr>
<tr>
<td>NA</td>
<td>0.8 ± 0.0</td>
<td>0.6 ± 0.1</td>
<td>1.1 ± 0.1</td>
<td>0.3 ± 0.2</td>
<td>1.0</td>
<td>0.0</td>
<td>0.8</td>
<td>0.1</td>
<td>1.6</td>
</tr>
<tr>
<td>CK-MB</td>
<td>409 ± 175</td>
<td>678 ± 864</td>
<td>731 ± 1091</td>
<td>830 ± 703</td>
<td>671 ± 258</td>
<td>64</td>
<td>227</td>
<td>281</td>
<td>300</td>
</tr>
<tr>
<td>Troponin</td>
<td>59 ± 33</td>
<td>131 ± 227</td>
<td>152 ± 607</td>
<td>152</td>
<td>227</td>
<td>670</td>
<td>66</td>
<td>227</td>
<td></td>
</tr>
</tbody>
</table>

The presented values are the mean ± standard deviation (SD).

BD 0.5h-4h—brain dead group with period of ventilation and circulatory stabilization time; CK-MB—Creatine kinase (myocardium); Control—immediately sacrificed without intervention; EM—explosive brain death induction model, expansion of the fogarty catheter in 60 sec. with a pump; GM—gradual brain death induction model, expansion of the fogarty catheter over a period of 30 min. with a pump; NA—Noradrenalin

BRAIN DEATH INDUCTION SPEEDS AND PULMONARY EFFECTS
REFERENCES


