Respiratory physiotherapy in the pulmonary dysfunction after cardiac surgery

Fisioterapia respiratória na disfunção pulmonar pós-cirurgia cardíaca

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Abstract

The aim of this study is to make a literature review about the different techniques of respiratory physiotherapy used after cardiac surgery and their effectiveness in reverting pulmonary dysfunction. It has been used as reference publications in English and Portuguese using as keywords thoracic surgery, respiratory exercises, physiotherapy modalities, postoperative complications and coronary artery bypass grafting, contained in the following databases - BIREME, SciELO Brazil, LILACS, PUBMED, from 1997 to 2007. A secondary study through list of references of identified articles also was performed. It has been selected eleven randomized trials (997 patients). Among the articles included in this study, incentive spirometry was used in three; deep breathing exercises in six; deep breathing exercises associated with positive expiratory pressure in four and positive expiratory pressure associated with inspiratory resistance in two. Three studies used intermittent positive pressure breathing. Continuous positive airway pressure and bi-level positive airway pressure has been used in three and two studies respectively. The protocols used in the studies were varied and the co-interventions were present in most of them. The different analyzed variables and the time of postoperatory follow-up make a comparative analysis difficult. Pulmonary dysfunction is evident in the postoperatory period of cardiac surgery. The use of non-invasive ventilation has been associated with good results in the first postoperatory days. Despite the known importance of postoperatory respiratory physiotherapy, until now, there is no consensus in the literature about the superiority of one technique over the others.


This study was carried out at Instituto de Previdência dos Servidores do Estado de Minas Gerais – IPSEMG.

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METHODS

Search Strategy
Using a primary and secondary search strategy, we performed a literature review of the different techniques of respiratory physiotherapy used in the PO of heart surgery and their effectiveness in the reversion of pulmonary dysfunction, using as publications in English and Portuguese as references. The descriptors used were thoracic surgery, respiratory exercises, physiotherapy modalities, postoperative complications and CABG, and were searched for in the following data sources: BIREME, SciELO Brazil, LILACS and PUBMED from 1997 until 2007. We avoided an excess of similar studies. A secondary search through the considered articles’ list of references was also performed.

Criteria for the selection of studies
Randomized clinical studies were selected for analysis if they had more than 20 patients and adults who had undergone HS, and if they compared different techniques of respiratory physiotherapy, or if they compared these techniques to procedures without respiratory physiotherapy in the PO. We also selected articles about HS and its pulmonary repercussions in order to introduce the subject and provide a stronger theoretical base.

Variables analyzed
The analyzed variables included pulmonary oxygenation (oxygen saturation - SatO₂, partial pressure of oxygen in arterial blood - PaO₂, oxygenation index - PaO₂/FiO₂) [20,22-28]; lung function measured by spirometry (forced expiratory volume in the first second - FEV₁, vital capacity - VC, forced vital capacity - FVC, peak expiratory flow - PEF, forced expiratory flow between 25 and 75% of FVC - FEF 25-75%) [20-22,24,26,29,30]; chest x-rays, including signs of atelectasis [20,21,23,24,26]; time of hospital stay [20,23]; rates of lung infection [20,23], respiratory muscle strength (maximum inspiratory pressure - MIP, and maximal expiratory pressure - MEP) [27,29,30]. Two of the included studies analyzed the results of thoracic computed tomography (TCT) [22,28].
RESULTS AND DISCUSSION

In most cases, patients undergoing HS develop PO pulmonary dysfunction [32] with a significant reduction in lung volume [15,21,22,24,32,33], damage to respiratory mechanics [13,14], a decrease in lung compliance, and increased respiratory work [31,34]. The reduction in lung volume and capacity contributes to changes in gas exchange, resulting in hypoxemia [15,17,28,33,35] and decreasing diffusion capacity [21]. Restrictive presentation often persists over more than 116 days [32,36].

The most common radiological changes observed in the PO is atelectasis [22,26,28,36,37]. These findings were radiologically confirmed [21] by TCT [28], mainly in relation to the left lower lobe. Atelectasis is related to damage in gas exchange and reduction in lung volumes, and reduces functional residual capacity (FRC) and lung compliance. Atelectasis is considered clinically relevant when it grows or is persistent, when it is associated with hypoxemia, or when there is an increase in respiratory work or others signs of effort [37]. However, O’Donohue et al. [37] reported that only a small fraction of these patients will present severe clinical complications. Findings on pleural effusion are also frequent. It was found at a rate of 32% and 43.9% on the 2nd and 3rd postoperative day (POD), respectively [20]. Westerdahl et al. [21] found it in 63% of patients on the 4th POD, data similar to the study of Vargas et al. [38], on which the authors used TCT as preliminary tool.

A decrease in the expansion of lower lung lobes is often caused by a weak cough, a reduction in mobility, and muscle fatigue associated with physiological respiratory and diaphragmatic changes that result in superficial and predominantly thoracic breathing [39]. Lung damage in reinflation may maintain or worsen the patient’s poor condition, which will contribute to the development of pneumatic processes [19].

Lung infections, whose prevalence ranges between 3.5% [23] and 10% [20], also contribute to the morbidity related to HS. Westerdahl et al. [22] found no signs of lung infection in any of the patients the authors included. It is important to note that there is no consensus about the diagnostic criteria being cited, including radiological changes [23], the presence of leukocytosis [23], elevated body temperature [20,23], and the isolation of pathogens in cultures or sputum microscopy [20,23].

Taking into account the presentation of pulmonary dysfunction associated with HS and its possible repercussions, a better understanding and more research about the available resources today to reverse this situation is crucial. Within this context, respiratory physiotherapy has increasingly been requested [40], because it uses techniques capable of improving respiratory mechanics, pulmonary re-expansion and bronchial hygiene [22,41]. However, systematic review of the literature shows that there are controversies about the aforementioned subject, making it difficult to decide which resource would be more useful and less expensive in the management of these patients [42]. The techniques used in respiratory physiotherapy vary by country and practice.

In order to evaluate the different techniques of respiratory physiotherapy used in PO HS and their effectiveness in reversing pulmonary dysfunction, 11 randomized clinical trials (Table 1) were selected. These trials were performed in five countries with adults who had undergone HS. All trials included had samples larger than 20 patients. Among the studies included, incentive spirometry (IS) was performed in three of them [20,24,27], deep breathing exercises (DBE) were used in six [20,21,23,28-30]; DBE associated with positive expiratory pressure (PEP) was used in four [21,22,28,29] and PEP associated with respiratory resistance (PEP-IR) was used in two [21,28]. Breathing with intermittent positive pressure (BIPP) was used in three studies [25,27,30]; continuous positive airway pressure (CPAP) was used in two [24,26], bi-level positive airway pressure (BiPAP) was used in three studies [24-26]. Two clinical trials used a control group that didn’t receive respiratory physiotherapy [22,23].

The studies included ranged from 21 [30] to 198 [23] patients, totaling 997 patients, and there was a variable of no uniformity among the analyzed studies (more specifically, among the patient profiles). Westerdahl et al. [21] restricted the studied population to males. Three studies [22,29,30] reported the inclusion of patients who underwent HS, not specifying the type of performed surgeries. Brasher et al. [23] included patients who underwent coronary artery bypass grafting (CABG) and valve replacement. Only five studies described the techniques of randomization used [20,21,23,26,27].

The use of IS in the U.S. has reached 95% in cases of atelectasis [43], and it is performed by slow and deep breaths starting at FRC and reaching total lung capacity, sometimes followed by sustained respiration [44], and provides a visual feedback for patients. Several studies have reported the use of IS in PO HS [20,24,27]. The technique provokes an increase in negative pleural pressure, thus increasing transrespiratory pressure and ultimately causing better gas flow between the airways to the alveoli, as well as increased lung expansion [44].

The studies compared the performance of incentive spirometry volume with different techniques, including CPAP [24], DBE [20], BIPP [27], BiPAP [24]. In one study [24], IS was associated with less favorable results in the improvement of VC, FEV1 and PaO2 when compared to other techniques (CPAP and BiPAP). In another randomized clinical trial [20], the addition of IS to respiratory physiotherapy (DBE, early mobilization and techniques of
Table 1. Summary of the Included Studies

<table>
<thead>
<tr>
<th>Author/ Date/ Type of study</th>
<th>Population</th>
<th>Groups/protocol</th>
<th>Variable analyzed</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crowe and Bradley [20]/ 1997/ RCT</td>
<td>PO high-risk CABG (n=185)</td>
<td>RCT + EM (n=95); RCT + IS + EM (n=90)*</td>
<td>TCT/ PFT (FVC, VEF); SatO2/ pulmonary infection/ hospital stay</td>
<td>No significant difference between the groups</td>
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<tr>
<td>Matte et al. [24]/ 2000/ RCT</td>
<td>PO CABG (n=90)</td>
<td>IS + EM (n=30); IS + EM (n=30) 5 cmH2O 1 hour every 3 hours; BiPAP+ EM (n=30) 12.5 cmH2O 1 hour every 3 hours</td>
<td>Blood gas/ PFT (VC, VEF)/ TCT</td>
<td>BiPAP and CPAP showed superior to IS in blood gas assessment and PFT, between 1st e 2nd DPO (P&lt;.001)</td>
</tr>
<tr>
<td>Westerdahl et al. [21]/ 2001/ RCT</td>
<td>PO CABG (n=98)</td>
<td>PEP 3 x 10+ EM (n=36); PEP-IR 3 x 10 + EM (n=32)</td>
<td>PFT (VC, CI, VEF, FRC, VR, TPC) / diffusion of carbon dioxide / VAS/ TCT</td>
<td>No significant difference between the groups</td>
</tr>
<tr>
<td>Brasher et al. [23]/ 2003/ RCT</td>
<td>PO CABG and valve replacement (n=198)</td>
<td>DBE 4 x 5*+ EM (n=97); EM (n=101)</td>
<td>SatO2/ verbal pain scale/ temperature/ TCT/ pulmonary complications/ hospital stay</td>
<td>No significant difference between the groups</td>
</tr>
<tr>
<td>Westerdahl et al. [22]/ 2005/ RCT</td>
<td>PO CABG (n=61)</td>
<td>DBE 3 x 10 + EM (n=21); PEP 3 x 10 + EM (n=20); PEP-IR 3 x 10 + EM (n=20)</td>
<td>TCT/ PaO2 / PaCO2 before and immediately after intervention</td>
<td>Reduction in atelectatic areas (P&lt;.001) and improvement of oxygenation (P&lt;.05) in the three groups (no significant difference between the groups)</td>
</tr>
<tr>
<td>Pasquina et al. [26]/ 2004/ RCT</td>
<td>PO heart surgery (n=150)</td>
<td>CPAP (n=75) 5 cmH2O 4x 30 min; BiPAP (n=75) with PSV adjusted for VC 8-10 ml/kg and PEEP 5 cmH2O 4x30 min</td>
<td>PFT (VC, VEF)/ TCT/ arterial gasometry/ VAS</td>
<td>BiPAP is superior to CPAP compared to atelectasias resolution (P&lt;.02); no significant difference between the groups compared to PFT</td>
</tr>
<tr>
<td>Borghi-Silva et al. [29]/ 2005/ RCT</td>
<td>PO heart surgery (n=24)</td>
<td>PEP 3 x 20 + DBE 5x 20 + EM (n=8); DBE + EM (n=16) 5x 20</td>
<td>PFT (VC, VFC, VEF, FEF25-75%)/ PImax/ PEmax</td>
<td>PEP + DBE was more effective in recovery of pulmonary function and RMS (P&lt;.05)</td>
</tr>
<tr>
<td>Westerdahl et al. [28]/ 2005/ RCT</td>
<td>PO CABG (n=90)</td>
<td>PEP + EM 3 x 10* (n=48); EM (n=42)</td>
<td>PFT (VC, FVC, VEF, CI, FRC)/ TCT/ PaO2/ body temperature</td>
<td>Patients who performed exercises with PEP showed smaller atelectatic areas (p&lt;.05) and less reduction in VEF, and FVC (P&lt;.01)</td>
</tr>
<tr>
<td>Mendes et al. [30]/ 2006/ RCT</td>
<td>PO heart surgery (n=21)</td>
<td>BIPP 20-30 cmH2O - PEEP 10 cmH2O + DBE 5x 20 + EM (n=8); DBE 5x20 + EM (n=13)</td>
<td>PFT (VC, VEF, FEF25-75%, PEFR)/ PImax/ PEmax</td>
<td>No significant differences between groups</td>
</tr>
<tr>
<td>Muller et al. [25]/ 2006/ RCT</td>
<td>PO CABG (n=40)</td>
<td>CPAP 5 cmH2O 15 min/ h at 3 1* hs and 30 min at 24th e 48th h (n=20); BIPP 20-30 cmH2O 15 min/ h at 3.1* hs and 30 min at 24th e 48th h (n=20)</td>
<td>VC, FR, dispnea index, the use of accessory muscle, chest X rays/ arterial gasometry</td>
<td>More effective BIPP with improvement in dyspnea levels, FR and use of accessory muscle (P&lt;.01) and chest X rays. Both resources equally effective for gasometric variables (P&lt;.05)</td>
</tr>
<tr>
<td>Romanini et al. [31]/ 2007/ RCT</td>
<td>PO CABG (n=40)</td>
<td>IS 2 x 10 min (n=20); BIPP 2 x 10 min (n=20)</td>
<td>FR/ MV/ VC/ SatO2/ VC/ PImax/ PEmax</td>
<td>More efficient BIPP to hypoxemia reversion (P&lt;.01) / IS to improve respiratory muscle strength (P&lt;.05)</td>
</tr>
</tbody>
</table>

**TPC:** Total pulmonary capacity; **VAS:** Visual analogic scale; **RCT:** Randomized clinical trial; **EM:** Early mobilization; **TCT:** Thoracic computed tomography; **PFT:** Pulmonary function test; * Guidance to perform; independently throughout the day
bronchial hygiene) was not more effective than the respiratory physiotherapy alone in reducing the occurrence of pulmonary complications, the length of hospital stay, radiological pulmonary function or SatO2 improvement. In the early days of PO HS, the use of such resources was associated with greater difficulty in lung expansion due to restrictive factors such as pain [27], with questionable potential to prevent subsequent damage in lung function [24]. Romanini et al. [27] showed that IS was more effective than BIPP in strengthening the respiratory muscles, because it provides greater recruitment of motor units. However, it was less effective when used to reverse hypoxemia [27].

There were a variety of study protocols. There was no uniformity among the number of breathing treatments, the time of sustained respiration, or the number of series performed throughout the day, making it difficult to compare results. Some authors have suggested the treatment time [27]; others, the number of repetitions [24]. One of the studies did not provide this data; however, patients were instructed to perform exercises every hour [20]. The number of repetitions recommended by Matte et al. [24] was 20 every 2 hours. When using the time as parameter, two series of 10 minutes with an interval of five minutes between them were used [27].

DBEs, an easy-to-perform technique in which mechanical resources were not used, is also frequently preferred, consisting of slow and uniform nasal breathing followed by relaxed and uniform oral exhaling, aiming to increase lung expansion [22,41]. It is common to add positive expiratory pressure (PEP) to DBEs [22]. The provided expiratory resistance allows for slower emptying of the lungs and increased lung volume, preventing or reducing alveolar collapse and favoring expectoration [21,28]. The association of the respiration resistance with PEP (PEP-IR) focuses on active breathing, increasing the diaphragmatic demand and improving recovery [21].

Borghi-Silva [29] found better recovery of pulmonary function in the group that used PEP associated with DBEs and early mobilization (n=8), when compared to DBE and early mobilization alone (n=16). The authors noted that the use of PEP was more effective in restoring inhalation muscle strength. Using TCT, Westerdahl et al. [22] noted smaller areas with atelectasis in patients who underwent the DBE program associated with PEP compared to the control group, which had not performed breathing exercises, or which underwent only early mobilization. Spirometric variables were also close to the preoperative values; however, no differences were noted in terms of hospital stay and fever [22]. Some authors reported a significant decrease of the areas with atelectasis [28] and improvement in PaO2 [28] after performing DBE, PEP-IR and PEP, with no significant difference between the groups.

Other studies were performed in order to compare the effectiveness of DBE with other forms of respiratory physiotherapy [20,30] or with groups that did not receive respiratory physiotherapy during PO HS [23]. These studies failed to prove any superiority of DBEs. This may have occurred due to the patients’ questionable adherence to the proposed treatment. It is crucial to fully perform the exercises in order to achieve effective treatment. For example, the deeper the breaths, the greater the chances for curing atelectasis will be [21].

Regarding this technique, there was also no uniformity in exercise time or the number of series. The DBEs were performed in four series of five breaths with 3 seconds of sustained breathing [23], five series of 20 exercises with a diaphragmatic breathing pattern and with fractionated breaths [29,30]. In Westendahl et al.’s studies [21,22,28], there were three series of 10 exercises with all the proposed techniques - DBE, PEP and PEP-IR. Most authors monitored the patients’ exercises throughout the day [20-23].

CPAP, BiPAP and BIPP are ways to achieve non-invasive ventilation (NIV). Either a nasal or facial mask is used, which serves as an interface between the patient and the ventilator [45,46]. Such methods of ventilation serve to reduce respiratory function and improve respiratory gas exchange [45,46]. Positive effects were observed with the use of NIV, including improvements in BIPP [25,27], BIPP associated with PEP [30], CPAP [24-26] and BiPAP [24,26] in the first days after HS, when the breathing is characterized by low tidal volume, offset by increased respiratory rate [24]. The adoption of this pattern of breathing tends to favor the development and continuity of atelectasis and changes in gas exchange [25,26]. Compared to CPAP [25] and IS [27], BIPP was considered more effective in increasing tidal volume, providing pulmonary re-expansion with less ventilation function [25,27]. When compared to global mobilization and DBE, no additional effects related to the technique were observed [30].

It is important to point out that, despite the need for more intensive supervision, NIV does not depend on the patient’s cooperation, and causes less pain [24,27]. Matte et al. [24] noted the superiority of BiPAP on CPAP due to the decrease in pulmonary shunts. Pasquini et al. [26] showed that BiPAP is better when compared to CPAP in promoting the reduction of atelectatic areas under chest radiography. However, the authors concluded that the resources are equally effective in reducing the negative effects of HS on lung function [24,26]. There were no studies comparing BiPAP to BIPP.

Commonly, CPAP was performed with pressure of 5 cmH2O [24-26], lasting 1 hour in each 3-hour period [24], 15 minutes every hour in the first three hours after extubation [25], and for 30 minutes in the 24th and 48th hours [25], or for 30 minutes four times a day [26]. Bi-PAP was used for 1 hour in each 3-hour period, with breathing pressure of 12
cmH₂O and expiratory pressure of 5 cmH₂O [24], and four times daily for 30 minutes (expiratory pressure of 5 cmH₂O and breathing pressure sufficient to maintain the appropriate current volume) [26]. The BIPP technique was performed with pressure from 20 to 30 cmH₂O [26,31] for 15 minutes every hour in the first three hours after extubation, and for 30 minutes in the 24th and 48th hours [25], or three sets of 20 associated with a positive expiratory pressure of 10 cmH₂O [30]. Romanini et al. [27] applied BIPP in two sets of 10 minutes, with an interval of 5 minutes between them; however, the authors did not report the value of the pressure used. Hemodynamic effects associated with the application of positive pressure were not observed in any of the studies.

Co-interventions were present in most of the studies [21-24,26-30] and were not mentioned in only two of them [25,27]. The evaluators were blinded in five studies [21,22,25,26,28] and the patients in only one [26]. In Brasher et al’s study [23] and Crowe and Bradley’s study [20], only the radiologist was not aware of the allocation of patients.

A record of patient adherence to the treatment was maintained in some of the studies [20,23], which reported that only 15 of the 90 patients who underwent IS (16.6%) recorded its use. In another study, 79.4% of patients filled out the documentation form [23].

The use of effective methods of patient self-documentation may help to improve the reliability of results. It is important to ensure that the resources are within the patient’s reach, allowing for its use throughout the day as recommended in the intervention protocols. Such care can ensure a higher rate of adherence. The variability in the studies’ results may therefore arise from different frequencies of exercises performed, as well as the change in cooperation and commitment of the patients and professionals involved.

There was no uniformity among the days on which the patients underwent PO evaluation, ranging from 3 hours after extubation [25] to the 5th POD [25,29,30]. In one study, the evaluation was performed at the hospital [20]. This finding may be another contributing factor to the range of results. When no complications occur, the variables available tend to gradually return to preoperative levels, and favor the differences observed.

The variables analyzed were diverse, and the criteria used to evaluate a given variable were not homogeneous. The use of more sensitive diagnostic tests could have helped the analysis of the effects of respiratory physiotherapy in some of the studies included [22,28]. Using TCT, Westherdahl et al. [28] found significant improvement in oxidation levels and a reduction of atelectasis areas with only one set of breathing exercises.

We have observed that, despite the frequent recommendation of respiratory physiotherapy in the PO of HS and the wide range of techniques used to reverse the frequent pulmonary dysfunction in this period, there is no consensus about the best method to use. Studies [24-27] demonstrate the positive effects of NIV, especially BIPP [25,27] and BiPAP [24,26] in the first PO days. PEP showed positive results when compared to no breathing exercises [22] and DBE [29]. However, studies using TCT and gasometric analysis [21,28] and with more representative samples did not prove their superiority to DBEs. The results of these analyses suggest equality among DBE, PEP and PEP-IR. It is important to emphasize the importance of the professionals’ experience and the exactness of the techniques, as well as the dedication of the patients and the teams involved in their care.

CONCLUSION

It is clear that HS commonly causes changes in lung function, as well as the use of respiratory physiotherapy intervention in reversing such changes. In the early PO days, when the pain is frequent, and there is the presence of drains and little cooperation from the patient, NIV - mainly BIPP and BiPAP - has been proven effective in the reversal of pulmonary dysfunction and prevention of complications. However, there is no consensus in the literature on the most appropriate physiotherapy technique in this period. There is need for well-designed studies and with comparable methods and techniques, including combined applications, performed with the aim of establishing effective programs for different practices and patient profiles.

REFERENCES


