Although chest compressions (CCs) are an infrequent event in newly born infants (≈0.08% for near-term and term deliveries),1,2 outcome studies of delivery room resuscitations have reported high rates of mortality and neurodevelopmental impairment in those infants receiving CC or epinephrine.1,2 The poor prognosis associated with receiving cardiac compressions alone or with medications in the delivery room raises questions as to whether improved cardiopulmonary resuscitation (CPR) methods specifically tailored to the newborn could improve outcomes.3 Current resuscitation guidelines recommend a 3:1 compression:ventilation (C:V) ratio; however, the most effective C:V ratio in newborns remains controversial.4

**Background**—Guidelines on neonatal resuscitation recommend 90 chest compressions (CCs) and 30 manual inflations (3:1) per minute in newborns. The study aimed to determine whether CCs during sustained inflations (SIs) improves the recovery of asphyxiated newborn piglets in comparison with coordinated 3:1 resuscitation.

**Methods and Results**—Term newborn piglets (n=8/group) were anesthetized, intubated, instrumented, and exposed to 45-minute normocapnic hypoxia followed by asphyxia. Piglets were randomly assigned to receive either 3:1 resuscitation (3:1 group) or CCs during SIs (SI group) when the heart rate decreased to 25% of baseline. Piglets randomly assigned to the SI group received SIs with a pressure of 30 cm H2O for 30 s. During the SI, CCs at a rate of 120/min were provided. SI was interrupted after 30 s for 1 s before a further 30-s SI was provided. CCs were continued throughout SIs. CCs and SI were continued until the return of spontaneous circulation. Continuous respiratory parameters, cardiac output, mean systemic and pulmonary artery pressures, and regional blood flows were measured. Mean (standard deviation) time for return of spontaneous circulation was significantly reduced in SI group versus 3:1 group (32 [11] s versus 205 [113] s, respectively). In the SI group, administration of oxygen and epinephrine was significantly lower, whereas minute ventilation and exhaled CO2 were significantly increased. The SI group had significantly higher mean systemic and pulmonary arterial pressures during resuscitation in comparison with the 3:1 group (51 [10] versus 31 [5] mm Hg; 41[7] versus 31 [7] mm Hg, respectively; all P<0.05), with improved cardiac output and carotid blood flow.

**Conclusions**—Combining CCs and SIs significantly improved the return of spontaneous circulation with better hemodynamic recovery in asphyxiated newborn piglets in comparison with standard coordinated 3:1 resuscitation. (Circulation. 2013;128:2495-2503.)

**Key words:** cardiopulmonary resuscitation ■ chest wall oscillation ■ infant, newborn ■ ischemia ■ resuscitation

Background
diagramFigure

Antegrade blood flow during CPR can be achieved by either direct cardiac compression between the sternum and vertebral column or increased intrathoracic pressure produced by CC alone.5 Animal studies and human randomized trials have demonstrated that continuous CC without rescue breaths increases the return of spontaneous circulation (ROSC) and survival after sudden cardiac collapse.6,7 However, in newborns, when cardiac arrest is attributable to asphyxia, the combination of ventilation and CC is necessary to achieve ROSC.6,8 Furthermore, maneuvers that raise the intrathoracic pressure can dramatically increase carotid blood flow during CPR further augmenting antegrade blood flow.9,10 Chandra et al9 combined ventilation at high airway pressure while simultaneously performing CC in an animal model and demonstrated increased carotid flow, without compromising oxygenation.
Further, animal studies have demonstrated that a sustained inflation (SI) also increases intrathoracic pressure without impeding blood flow. However, no study has been conducted to examine whether combined simultaneous CC and SI will increase intrathoracic pressure to improve blood flow, resulting in increased ROSC and survival. We hypothesized that the use of SI during CPR would reduce the time needed to achieve ROSC. In addition, we also compared the hemodynamic recovery and survival between SI and CC and 3:1 CPR.

**Methods**

Twenty newborn mixed-breed piglets (1–4 days of age, weighing 1.6–2.1 kg) were obtained on the day of experimentation from the University Swine Research Technology Centre. All experiments were conducted in accordance with the guidelines and approval of the Animal Care and Use Committee (Health Sciences), University of Alberta. A graphical display of the protocol is presented in Figure 1.

**Randomization**

Piglets were randomly allocated to sham-operated, 3:1, or SI groups. Allocation was block randomized with variable sized blocks (2–4) by using a computer-generated randomization program (http://www.randomizer.org). A sequentially numbered, sealed, opaque envelope containing the allocation was opened before the start of the experimental protocol.

**Animal Preparation**

Piglets were instrumented as previously described with some modifications. In brief, following the induction of anesthesia, piglets were intubated via a tracheostomy, and pressure-controlled ventilation (Sechrist infant ventilator, model IV-100; Sechrist Industries, Anaheim, CA) was commenced at a respiratory rate of 16 to 20 breaths/min and pressure of 19/4 cm H₂O. Oxygen saturation was kept within 90% and 100%, and glucose level and hydration were maintained with an intravenous infusion of 5% dextrose at 10 mL·kg⁻¹·h⁻¹ and a 0.9% NaCl at 2 mL·kg⁻¹·h⁻¹, respectively. During the experiment, anesthesia was maintained with intravenous propofol 10 mg·kg⁻¹·h⁻¹ and pancuronium 0.05 to 0.1 mg·kg⁻¹·h⁻¹. Additional doses of propofol (0.5–1 mg/kg) and acepromazine (0.25 mg/kg) were also given as needed. The piglet’s body temperature was maintained at 38.5°C to 39.5°C by using an overhead warmer and a heating pad. A double-lumen catheter was inserted into the right atrium via the femoral vein for the administration of fluids and medications and central venous pressure (CVP) measurements. A single-lumen catheter was inserted into the distal aorta via the femoral artery for continuous arterial blood pressure monitoring. After intubation, the left common

![Study flow diagram](http://circ.ahajournals.org/Downloaded from http://circ.ahajournals.org)
Carotid artery was exposed and encircled with a real-time ultrasonic flow probe (2 mm; Transonic Systems Inc, Ithaca, NY) to measure blood flow. A left flank incision was used to open the peritoneum to measure superior mesenteric and left renal arterial blood flow with Transonic flow probes (3 mm and 2 mm, respectively). A left anterior thoracotomy was then performed to place a 6-mm Transonic flow probe around the main pulmonary artery (PA) to measure blood flow, which served as the surrogate of cardiac output. In addition, a 20 gauge Arrow angiocatheter (Arrow International, Reading, PA) was inserted to continuously measure mean pulmonary artery pressure (PAP). The ductus arteriosus was ligated and the thoracotomy was closed in 2 layers. Mean systemic arterial pressure (MAP), heart rate, percutaneous oxygen saturation, PAP, and CVP were measured with a Hewlett Packard 78833B monitor (Hewlett Packard Co, Palo Alto, CA). Piglets were put in a supine position and allowed to recover from surgical instrumentation until baseline hemodynamic measures were stable. The ventilator rate was adjusted to keep the partial arterial CO2 pressure of 35 and 50 mmHg as determined by periodic arterial blood gas analysis. Heart rate, oxygen saturation, MAP, PAP, CVP, and the blood flow at PA, left common carotid, superior mesenteric, and left renal arteries were continuously monitored and recorded throughout the experiment.22

Respiratory Parameters

A respiratory function monitor (Respironics, Philips, Andover, MA) was used to continuously measure tidal volume (VT), airway pressures, gas flow, and exhaled CO2 (ECO2). The combined gas flow and ECO2 sensor was placed between the endotracheal tube and the ventilation device. VT was calculated by integrating the flow signal. ECO2 was measured by using nondispersive infrared absorption technique. According to the manufacturer, the accuracy for the gas flow is ±0.125 L/min and for ECO2 ±2 mmHg. Respiratory function data were only recorded in 12 asphyxiated piglets (6 in each group) because of a malfunction of the respiratory function monitor.

Experimental Protocol

Piglets were randomly assigned to receive either coordinated CPR with a 3:1 ratio or CCs during continuous SI (Figure 1). All piglets were exposed to 45-minute normocapnic hypoxia. Hypoxia was followed by an asphyxia period until heart rate decreased to 25% of baseline, which was achieved by disconnecting the ventilator and clamping the endotracheal tube. Fifteen seconds after the heart rate reached 25% of baseline, positive pressure ventilation was commenced for 30 s with a Neopuff T-Piece (Fisher & Paykel, Auckland, New Zealand). The default settings were a peak inflating pressure of 30 cm H2O, a positive end-expiratory pressure, Vt, inflation time, minute ventilation, and ECO2 were measured and analyzed by using Flow Tool Physiologic Waveform Viewer (Philips Healthcare, Wallingford, CT). The data are presented as mean±standard deviation for normally distributed continuous variables and median (interquartile range) when the distribution was skewed. Kaplan-Meier survival graphs were used and the proportions of surviving piglets to 4 hours after resuscitation of the 2 intervention groups were compared by z test. Data during the resuscitation from the intervention groups were compared by using the Student t test for parametric and the Mann-Whitney U test for nonparametric comparisons of continuous variables, and Fisher exact test for categorical variables. For all respiratory parameters, the median value for each piglet during CPR was calculated first, and then the mean of the median calculated was compared with the Student t test. Hemodynamic parameters were compared by using 1-way analysis of variance and 2-way repeated-measures analysis of variance with Bonferroni post hoc analysis as appropriate. P values are 2-sided and P<0.05 was considered statistically significant. Statistical analyses were performed with Stata (Intercooled 10, Statacorp, TX).

Results

Twenty newborn pigs were randomly assigned to the 3:1 group (n=8), the SI group (n=8), and the sham-operated group (n=4). There were no differences in baseline parameters between the groups (Table 1). The median (interquartile range) duration of asphyxia was similar within groups; 80 (72–123) s in the 3:1 group versus 116 (63–127) s in the SI group (P=0.958). Heart rate before the commencement of CC was also comparable between groups 53 (15–62) bpm in the 3:1 group versus 42 (15–49) bpm in the SI group, respectively (P=0.490). Table 1 represents values of pH, pCO2, lactate, and hemoglobin at the start of CPR (end of asphyxia), and the values of pH, pCO2, and lactate after reestablishment of ROSC, as well.

Resuscitation

Time to ROSC was significantly decreased in the SI group with 38 (23–44) s in comparison with 143 (84–303) s in the 3:1 group (P=0.0008). In the SI group, significantly more piglets survived to 4 hours after resuscitation than in the 3:1 group (7/8 [87.5%] versus 3/8 [37.5%], respectively; P=0.038; Figure 3).

During CPR, significantly fewer piglets in the SI group than in the 3:1 group received 100% oxygen 3/8 versus 8/8 (P=0.0042). In addition, no piglet in the SI group required intravenous epinephrine bolus to achieve ROSC in comparison with the 3:1 group (versus 7/8, P=0.0001), which received 17 boluses in total (P=0.0026). In the 3:1 group, there were 2.1±1.6 doses of epinephrine per piglet administered, with a maximum of 4 doses.

Sample Size and Power Estimates

Our primary outcome measure was CPR time to achieve ROSC. Previous observational data showed a mean±standard deviation ROSC of 180±25 s. We hypothesized that the use of SI during CPR would reduce the time to achieve ROSC. A sample size of 16 piglets (8 per group) was sufficient to detect a clinically important (33%) reduction in time to achieve ROSC (ie, 180 s versus 120 s), with 80% power and a 2-tailed α-error of 0.05.

Data Collection and Analysis

The demographics of study piglets were recorded. Transonic flow probes, heart rate, and pressure transducer outputs were digitized and recorded with custom Assist programming software (Data Translation, Ontario, Canada). Peak inflating pressure, positive end-expiratory pressure, Vt, inflation time, minute ventilation, and ECO2 were measured and analyzed by using Flow Tool Physiologic Waveform Viewer (Philips Healthcare, Wallingford, CT). The data are presented as mean±standard deviation for normally distributed continuous variables and median (interquartile range) when the distribution was skewed. Kaplan-Meier survival graphs were used and the proportions of surviving piglets to 4 hours after resuscitation of the 2 intervention groups were compared by z test. Data during the resuscitation from the intervention groups were compared by using the Student t test for parametric and the Mann-Whitney U test for nonparametric comparisons of continuous variables, and Fisher exact test for categorical variables. For all respiratory parameters, the median value for each piglet during CPR was calculated first, and then the mean of the median calculated was compared with the Student t test. Hemodynamic parameters were compared by using 1-way analysis of variance and 2-way repeated-measures analysis of variance with Bonferroni post hoc analysis as appropriate. P values are 2-sided and P<0.05 was considered statistically significant. Statistical analyses were performed with Stata (Intercooled 10, Statacorp, TX).
During CPR, the SI group had 119 (119–121) inflations/min until ROSC was achieved in comparison with 30 (29–32) inflations/min in the 3:1 group (P<0.0001). In addition, numbers of CCs in the SI group were significantly increased in comparison with the 3:1 group 119 (119–121) versus 90 (89–93) CCs/min (P<0.001), respectively.

Hemodynamic Parameters During CCs
PAP and MAP were significantly higher in the SI group than in the 3:1 group during CPR (Table 2). However, no difference in CVP or MAP/PAP ratio among groups was observed. Cardiac output as a reference for recovery was significantly increased in the SI group than in the 3:1 group (47±27% versus 14±23% of normoxic baseline, respectively, P<0.05). Figure 4 summarizes changes in PA and regional blood flows during the first 5 minutes after CPR was commenced. The piglets in the SI group had better systemic and regional hemodynamic recovery with significantly faster recovery of both PA and common carotid blood flows in the SI group than the 3:1 group (P<0.05; Figure 4).

Respiratory Parameters During CCs
V₆ was significantly higher in the 3:1 group versus the SI group (Table 3). However, in comparison with the 3:1 group,
**Table 1. Characteristics of Newborn Piglets at Baseline, at Commencement of CPR, and Once ROSC Was Restored**

<table>
<thead>
<tr>
<th>Characteristics at Commencement of CPR</th>
<th>3:1 Group (n=8)</th>
<th>SI Group (n=8)</th>
<th>Sham-operated Group (n=4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, days (±1)</td>
<td>2±1</td>
<td>2±1</td>
<td>2±1</td>
</tr>
<tr>
<td>Weight, g (±107)</td>
<td>1800±107</td>
<td>1800±107</td>
<td>1675±125</td>
</tr>
<tr>
<td>Male/female</td>
<td>7/1</td>
<td>6/2</td>
<td>4/0</td>
</tr>
<tr>
<td>Heart rate, bpm (±29)</td>
<td>237±22</td>
<td>222±29</td>
<td>214±17</td>
</tr>
<tr>
<td>Arterial pH (±0.7)</td>
<td>7.35±0.07</td>
<td>7.37±0.06</td>
<td>7.41±0.08</td>
</tr>
<tr>
<td>Arterial pco2, mm Hg (±5)</td>
<td>47±5*</td>
<td>46±4</td>
<td>38±7</td>
</tr>
<tr>
<td>Lactate, mmol/L (±1.2)</td>
<td>3.9±1.2</td>
<td>4.1±0.6</td>
<td>4.5±1.5</td>
</tr>
<tr>
<td>Arterial hemoglobin, g/L (±11.4)</td>
<td>83.4±11.4</td>
<td>84.6±12.4</td>
<td>77.3±23.5</td>
</tr>
</tbody>
</table>

**Table 2. Mean Pulmonary and Systemic Arterial Pressures and Central Venous Pressure Over the Duration of Chest Compressions**

<table>
<thead>
<tr>
<th>Characteristics after ROSC</th>
<th>3:1 Group (n=8)</th>
<th>SI Group (n=8)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arterial pH (±0.12)</td>
<td>6.92±0.12</td>
<td>6.96±0.07</td>
<td>7.37±0.08</td>
</tr>
<tr>
<td>Arterial pco2, mm Hg (±26)</td>
<td>87±12</td>
<td>79±12</td>
<td>42±8</td>
</tr>
<tr>
<td>Lactate, mmol/L (±3.4)</td>
<td>12±3.4</td>
<td>11.5±2.5</td>
<td>4.3±1.6</td>
</tr>
<tr>
<td>Base excess, mEq/L (±4.7)</td>
<td>−20±4.7</td>
<td>−18.6±2</td>
<td>−1.3±3.3</td>
</tr>
<tr>
<td>Arterial hemoglobin, g/L (±11)</td>
<td>84.7±11</td>
<td>89±16</td>
<td>79±24</td>
</tr>
</tbody>
</table>

Compressions and Sustained Inflations in Newborns

**Figure 3.** Kaplan-Meier survival graph for the 2 intervention groups after CPR in minutes. CC indicates chest compressions; CPR, cardiopulmonary resuscitation; PPV, positive pressure ventilation; and ROSC, return of spontaneous circulation.

**Discussion**

Current resuscitation guidelines recommend a 3:1 C:V ratio, but the most effective C:V ratio in newborns remains controversial. Recent neonatal piglet cardiac arrest studies compared various C:V ratios (3:1 versus 9:2 versus 15:2) and did not report any difference in ROSC, mortality, oxygen delivery, hemodynamics, or epinephrine administration. In addition, current resuscitation guidelines recommend 120 events/min, which comprise 90 CCs and 30 inflations. A recent mathematical study suggests that the most effective CC frequency during CPR depends on body size and weight. For newborn infants, CC rates >120/min may be more beneficial and improve survival. To our knowledge, no study has examined the differences of CCs during SI and compared this with the current standard 3:1 C:V ratio. In the current study, we delivered 120 CCs/min during SI, which passively delivered an adequate V̇e. The results of this study can be summarized as follows: (1) CCs with SI significantly reduced time to ROSC, mortality (Figure 3), epinephrine administration, and improved systemic and regional hemodynamic recovery (Table 2); (2) minute ventilation, and therefore alveolar oxygen delivery, was significantly increased in the SI group (Table 3); (3) CCs during SI forced V̇e out of the chest, and the passive chest recoil allowed air to be drawn back into the lungs (Figure 2B). We speculate that (1) a significant increase in MAP (and therefore possibly higher coronary artery pressure; Table 2), (2) faster recovery of systemic and regional blood flows (Figure 4), and (3) increased minute ventilation, and therefore increased alveolar oxygen delivery (Table 3), may have contributed to the improved survival. Mechanisms to generate systemic blood pressure and blood flow include cardiac pump theory and thoracic pump theory. The cardiac pump theory postulates that direct cardiac compression ejects blood into the circulation, whereas the thoracic pump theory states that antegrade blood flow is a result of phasic increases in intrathoracic pressure. In the cardiac output in comparison with the sham-operated piglets (Table 4). The common carotid arterial and superior mesenteric arterial, but not renal, blood flows and MAP of both the SI and 3:1 groups were lower than those of the sham-operated group (Table 4). The heart rate, PAP, and CVP were not different among groups (Table 4). The arterial pH and lactate level of the surviving piglets in the SI and 3:1 groups were 7.30±0.07 and 6.0±2.8 mmol/L versus 7.25±0.17 and 5.8±3.3 mmol/L, respectively.
current study, continuous CCs during SI significantly improved PAP, MAP, cardiac output, and regional blood flow to the brain, kidneys, and intestines. Our results are supported by other large-animal studies, which have demonstrated that simultaneous CCs and ventilation generates higher intrathoracic and vascular pressure and enhances myocardial and cerebral perfusion.9,10,19,20,25–27 Similar observations in regard to increased blood pressure and carotid blood flow during simultaneous CCs and ventilation have been reported in a human trial.10 In contrast, interrupting CCs to deliver manual inflations resulted in substantial decreases in the aortic diastolic pressures and coronary perfusion pressures.24 Interestingly, studies in infant piglets were unable to demonstrate an increase in intrathoracic pressure or enhanced myocardial and cerebral perfusion during uninterrupted CCs.21,28 However, our model differentiates substantially from Berkowitz et al 21 and Hou et al.28 Berkowitz and Hou delivered 60 CCs/min in addition to 60 inflations/min. Our studies used 120 CCs/min, which is twice as many as Berkowitz and Hou used in their studies. The higher CC rate might have contributed to the improved blood flow. In addition, our model used peak inflation pressures of 30 cm H2O in comparison with the 60 cm H2O in the Berkowitz and Hou studies.21,28 The increased peak inflation pressures might have impaired blood flow. In addition, the delivered VT in our study was ≈14 mL/kg. Berkowitz and Hou used a peak inflation pressure of 60 cm H2O for their rescue breaths, which potentially delivered even higher Vt,s and might have caused increased lung tissue injury in the experimental group in Hou’s study.28 Overall, our model uses constant peak inflation pressure of 30 cm H2O for the duration of the SI to passively ventilate the lung, in comparison with the Berkowitz and Hou studies, in which 60 inflations/min were delivered. The Vt in our study was potentially limited to the force used to deliver CCs. Current

Table 3. Respiratory Parameters Over the Duration of Chest Compressions

<table>
<thead>
<tr>
<th></th>
<th>3:1 Group (n=6)</th>
<th>SI Group (n=6)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tidal volume, mL/kg</td>
<td>21.1±3.5</td>
<td>14.5±2.6</td>
<td>0.0039</td>
</tr>
<tr>
<td>Minute ventilation, mL·kg⁻¹·min⁻¹</td>
<td>623±116</td>
<td>936±201</td>
<td>0.0080</td>
</tr>
<tr>
<td>Exhaled CO₂, mmHg</td>
<td>12±10</td>
<td>32±10</td>
<td>0.0065</td>
</tr>
<tr>
<td>Peak inspiratory flow, L/min</td>
<td>6.7±0.8</td>
<td>8.3±0.9</td>
<td>0.0086</td>
</tr>
<tr>
<td>Peak expiratory flow, L/min</td>
<td>−10.0±2.3</td>
<td>−11.7±1.6</td>
<td>NS</td>
</tr>
<tr>
<td>Peak inflation pressure, cm H₂O</td>
<td>30.4±0.6</td>
<td>43.2±2.3</td>
<td>0.0001</td>
</tr>
<tr>
<td>Positive end-expiratory pressure, cm H₂O</td>
<td>4.3±2.2</td>
<td>19.5±2.7</td>
<td>0.0001</td>
</tr>
</tbody>
</table>

NS indicates not significant; and SI, sustained inflation.
The current resuscitation guidelines recommend 120 events/min, which comprise of 90 CCs and 30 inflations. In the SI group, we used 120 CCs/min, which may have contributed to the increased survival and improved hemodynamic parameters. In addition, animal studies have demonstrated that any maneuver that increases intrathoracic pressure can increase carotid blood flow.3,27 Chandra et al30 used total airway occlusion during CCs to significantly increase carotid blood flow. In the current experiment, we applied SI, which has been shown to increase intrathoracic pressure. In addition, animal experiments demonstrated that the delivery of a SI achieves uniform lung aeration and does not adversely affect cardiac output and cerebral blood flow and stabilizes neonatal cerebral oxygen delivery.11,29 Furthermore, a recent study in near-term asphyxiated lambs reported that a single SI of 30 s immediately after birth improved the speed of circulatory recovery and lung compliance.20 We combined continuous CCs with SI to maximize the increase in intrathoracic pressure, which significantly improved minute ventilation and regional and systematic hemodynamics. Improved lung aeration results in marked increases in pulmonary blood flow.11 An increase in oxygenated blood flow returning from the lungs restores cardiac function, resulting in increased coronary perfusion and cerebral blood flow during resuscitation.11,29 Furthermore, we did not observe any impairment of venous return or an increase in vascular shunts (Table 2).

The current resuscitation guidelines recommend a C:V ratio of 3:1, suggesting that CCs are interrupted after every third CC to deliver 1 inflation (Figure 2A), which would result in a decrease in intrathoracic pressure.5 The purpose of inflations during CPR is to deliver an adequate V T to facilitate gas exchange. In addition, each inflation increases intrathoracic pressure, which augments anastomotic blood flow.3 Recent studies measuring respiratory function in the delivery room demonstrated that V T in the initial stabilization period varies considerably in newborn infants.30,33 However, no study has measured the delivered V T during neonatal CPR to understand the effect of CCs on lung aeration and V T delivery. In the current study, we demonstrated that air is forced out of the chest during CCs, and an adequate V T is delivered during the passive chest recoil (Figure 2B). Figure 2B clearly demonstrated that, when CCs are performed during SI, air moves in and out of the chest. In this model, rescue breaths were not delayed as previously described in adults or adult models; instead, ventilation was passively achieved during CCs. This is a novel finding that has not been reported previously. The current resuscitation guidelines recommend 30 inflations/min in comparison with the 120 inflations/min used in the current study. Our approach increases the number of inflations per minute by a 4-fold, thus resulting in a significantly increase in minute ventilation. In addition, ECO2 was significantly increased in the SI group, indicating increased alveolar ventilation, pulmonary perfusion (right cardiac output), and CO2 production attributable to metabolism.32,33

Administration of 100% oxygen is recommended during CPR and can be reduced once an adequate heart rate and oxygen saturation are achieved.1 However, concerns have been raised about the potential adverse effects of increased fraction of inspired oxygen within the first 6 hours of life in newborns treated with therapeutic hypothermia.34–36 In the current study, only 3/8 piglets in the SI group required 100% oxygen during CPR in comparison with all 8/8 piglets in the 3:1 group. This is of important clinical relevance, because hyperoxia slows cerebral blood flow and can lead to the generation of oxygen-free radicals, a major cause in reperfusion injury after asphyxia.37

Animal studies during asphyxia-mediated arrest have demonstrated that epinephrine increases systemic vascular resistance, coronary artery perfusion pressure, and blood flow to the myocardium.38 However, the optimal dose and route to administer epinephrine in newborn infants remains controversial.4 In the current study, no piglet in the SI group required epinephrine in comparison with to 7/8 in the 3:1 group owing to their fast ROSC. This is of considerable clinical relevance because we demonstrated that optimal ventilation is the key for successful resuscitation. It is most likely that the increase in intrathoracic pressure causing significantly increased PAP, MAP, PA, and regional blood flows, minute ventilation, and higher oxygen delivery, as well, may have contributed to less epinephrine administration in the SI group. Further, Schmittenberg et al39 recently demonstrated histological features of stress-induced cardiotoxicity correlated with doses of epinephrine administration, thus cautioning about the potential adverse effects with the use of epinephrine.

Our use of a piglet asphyxia model is a considerable strength of this translational study, because this model closely mimics delivery room events with a gradual onset of severe asphyxia leading to bradycardia. However, several limitations should be considered before general application of simultaneous CCs and SI in future clinical neonatal resuscitation trials. The current model is one in which the piglets have already undergone fetal to neonatal transition, and the piglets are sedated/anesthetized. In addition, the piglets in our model were all intubated by the use of a tightly secured endotracheal tube to prevent any endotracheal tube leak; this is different from clinical situations where mask ventilation may be frequently used. Nevertheless, our findings remain relevant despite these limitations, because

### Table 4. Hemodynamic Parameters of Newborn Piglets at 4 Hours After Cardiopulmonary Resuscitation

<table>
<thead>
<tr>
<th>Parameter</th>
<th>3:1 Group (n=3)</th>
<th>SI Group (n=7)</th>
<th>Sham-operated Group (n=4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart rate, bpm</td>
<td>241±6</td>
<td>249±32</td>
<td>218±24</td>
</tr>
<tr>
<td>Mean arterial pressure, mm Hg</td>
<td>35±11*</td>
<td>40±9*</td>
<td>45±12</td>
</tr>
<tr>
<td>Pulmonary arterial pressure, mm Hg</td>
<td>30±5</td>
<td>35±6</td>
<td>29±3</td>
</tr>
<tr>
<td>Central venous pressure, mm Hg</td>
<td>5±1</td>
<td>6±2</td>
<td>6±3</td>
</tr>
<tr>
<td>Cardiac output</td>
<td>55±17*</td>
<td>86±58</td>
<td>137±21</td>
</tr>
<tr>
<td>Common carotid arterial flow, mL·kg⁻¹·min⁻¹</td>
<td>12±7*</td>
<td>13±8*</td>
<td>19±4</td>
</tr>
<tr>
<td>Superior mesenteric arterial flow, mL·kg⁻¹·min⁻¹</td>
<td>22±11*</td>
<td>26±21*</td>
<td>36±14</td>
</tr>
<tr>
<td>Renal arterial flow, mL·kg⁻¹·min⁻¹</td>
<td>2±2</td>
<td>7±6</td>
<td>4±3</td>
</tr>
</tbody>
</table>

*Values are mean±standard deviation. SI indicates sustained inflation. *P values <0.05 vs sham-operated.
the distribution of cardiac output in the fetus and posttransi-
tional neonate during asphyxial episodes are qualitatively sim-
ilar.13 Further, in the current study, the ductus arteriosus was
ligated in all piglets to help ensure that cardiac output could be
accurately assessed by PA blood flow. This is a limitation of
translation to delivery room resuscitations, because this method
will contribute to a decrease in vascular shunting. This war-
rants further studies with the use of animal models with patent
ductus arteriosus. Of note, giving 100% oxygen after 30 s of
CCs and the administration of epinephrine at 60 s after CCs
was started and continued every minute are not in line with the
current resuscitation guidelines.14 This might have influenced
our results; however, the piglets randomly assigned to the SI
group did not require a single dose of epinephrine in compar-
ison with 7/8 in the 3:1 group to achieve ROSC. The current
resuscitation guidelines recommend a peak inflation pressure
of 20 to 25 cm H2O during positive pressure ventilation in the
delivery room,4 but higher opening pressures may be needed
until functional residual capacity is established. In the current
study, a peak inflation pressure of 30 cm H2O resulted in large
delivered V̇e values, which has been shown to cause lung injury
to the premature lung.40 Because it is still unclear whether a SI
during the transition is injurious to the lung, an examination for
lung injury may have broadened the outcomes and significance
of this study. In addition, future assessment should include the
assessment of cerebral hemodynamics and brain injury.

Conclusions
Simultaneous CCs and SI during CPR in newborn piglets
significantly improved ROSC and survival in a porcine model
of neonatal resuscitation. This is of considerable clinical relevance,
because improved respiratory and hemodynamic parameters
potentially minimize morbidity and mortality in newborn infants.

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Disclosures
None.

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the lung while providing chest compressions. To achieve passive ventilation, we applied airway pressure of 30 cm H2O, which was sustained for the duration of the chest compressions. This novel approach significantly improved the return of spontaneous circulation and survival in newborn piglets. We observed improved lung aeration, which resulted in marked increases in pulmonary blood flow. An increase in oxygenated blood flow returning from the lungs restores cardiac function, resulting in increased systemic and pulmonary blood pressure and carotid blood flow during resuscitation. With the use of this new technique, significantly fewer piglets required supplemental oxygen and none required intravenous epinephrine administration. This may be of clinical relevance because hypoxia can lead to the generation of oxygen-free radicals, a major cause in reperfusion injury after asphyxia. Our results are of considerable clinical relevance, because improved respiratory and hemodynamic parameters potentially minimize morbidity and mortality in newborn infants.

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