Timing of Out-of-hospital Cardiac Arrest and Social Rehabilitation Rate

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Abstract

Timing of out-of-hospital cardiac arrests related to social rehabilitation. To clarify the influence of timing of out-of-hospital cardiac arrests to physical and neurological recovery rates, we conducted a multiple logistic regression analysis through nation wide records of cardiac arrest using Utstein templates. We identified 377,705 cases of witnessed out-of-hospital cardiac arrests. The multiple logistic regression models demonstrated that the odds ratio of timing for nighttime versus daytime was 0.78 (95% CI 0.76–0.81). We concluded that social rehabilitation following out-of-hospital cardiac arrest during nighttime is poorer than during daytime.

Background

It is difficult to conduct randomized controlled trials when studying cardiac arrest because of ethical limitations. In order to improve cardiopulmonary resuscitation (CPR) for patients suffering out-of-hospital cardiac arrest (OHCA), interventional studies are critical. Further, well-planned observational studies based on large-scale databases potentially reduce the harmful effects of confounding variables.

All OHCA cases reported by emergency medical personnel are available in the Utstein-templated database in Japan (the Utstein database) since January 2005; this database has become the standard for reporting cardiac arrest incidents since the conference held at the Utstein Abbey in Norway [1]. By using these databases, it is possible to analyze the efficacy of bystander CPR (BCPR) as well as the efficacy of emergency medical services [2]. Successful social rehabilitation without severe neurological or physical impairment after OHCA is one of the primary goals for emergency medical systems, and several studies using the Japanese Utstein database have been reported [3-5].

Though it is naturally important that the emergency medical system must be effective regardless of the time of the incidence, time of day reportedly affects outcomes in conditions such as stroke [6], ischemic heart disease [7], and pulmonary embolism [8], where outcomes are poorer when patients present at night. A study using the Utstein database from 2005 to 2008 also showed that the prognosis when patients present at night was worse than when they present during the day, and there was no significant difference of prognosis between weekdays and holidays [9]. A similar study evaluating the prognosis of children presenting with emergency medical conditions also found that prognosis was worse at night [10].

In the Utstein database, whether the cardiac arrest was witnessed by a bystander or not is recorded. The prognosis of cardiac arrest is known to depend upon the time span from occurrence of the cardiac arrest to the reception of proper CPR, and evaluating only witnessed cases is required to accurately analyze the dependency of time span on prognosis.

Purpose

The aim of this study is to elucidate the time dependency of cerebral recovery rates following OHCA using the Utstein database.
finally, social rehabilitation. The initial finding of the ECG was divided into the presence of ventricular fibrillation or pulse less ventricular tachycardia (VF/VT) and non-VF/VT. Defibrillated cases were divided into four types: defibrillated only by a bystander (public), only by EMS staff, by both public and EMS, and by no one. BCPR cases were also divided into 4 types: conventional CPR (chest compression and artificial ventilation), chest compression only, artificial ventilation only, and none. The period of cases was divided into 2005–2008 and 2009–2012. Time of request call was divided into daytime (from 09:00 to 16:59) and nighttime (from 17:00 to 08:59). Seasons were defined as spring (from March to May), summer (from June to August), autumn (from September to November), and winter (from December to February).

Outcome

Our outcome is social rehabilitation, defined as the grade 1 or 2 of Cerebral Performance Category in the Glasgow Pittsburgh Outcome Categories at one month following OHCA. All cases were divided into two groups (Figure 1): a “good” group that has normal or only mild impairment of cerebral performance (category 1 and 2), and a “poor” group that has moderate or severe impairment, brain death, or death (categories 3-5).

Statistical analysis

We summarized categorical variables using percentages and frequencies, and occurrences of OHCA were depicted in each hour. Chi square tests were used for categorical data between the two groups. We performed a multiple logistic regression analysis to assess the relationship between social rehabilitation and 14 variables. R (ver. 3.2.0, The R foundation, Austria) was used for statistical analysis.

Ethics

The Utstein database was analyzed with the permission of the Fire and Disaster Management Agency of the Ministry of Internal Affairs and Communications. This study was approved by the ethical committee of Kokushikan University (no. 27-010).

Results

We summarized categorical variables using percentages and frequencies among the good and poor groups (Table 1).

Figure 2 shows time dependency of arrest events and successful social rehabilitation. The overall successful rate of social rehabilitation was 5.5% (20,593 cases/377,705), and the two lowest rates were 3.9% between 18:00-18:59 and 4.1% between 04:00-04:59.

Results of the analysis using a multiple logistic regression are summarized in Table 2. Use of an automatic external defibrillator (AED) showed significantly high odds ratio (OR), especially in cases of public usage (9.49, 95% confidence interval 8.70-10.34). VT/VF also showed high an OR of1.99 (1.88-2.11) in the initial finding of ECG. The OR of 2009-2012 compared to 2005-2008 was 1.54 (1.49-1.59). The OR decreased with age as that of 85 years old and over was 0.24 (0.22-0.25). The OR of nighttime was 0.78 (0.76-0.81) compared with daytime. The OR of call-contact over 10 minutes was 0.59 (0.58-0.66) compared with 10 minutes and less. The OR of call-hospital interval over 60 minutes was 0.61(0.57-0.66) compared with 60 minutes and less.

Discussion

This nationwide study demonstrates that social rehabilitation following OHCA is worse when the event occurs during the night as
Our study also showed that AED use remarkably improves social rehabilitation, especially when a bystander (OR 9.49, 8.70-10.34) used AED-assisted CPR faster than EMS staff and this can shorten the interval between decision making and adrenalin administration. 

In this study, the OR was 0.59 (95% CI 0.57-0.62) when the call contact interval was over 60 minutes, and 0.61 (95% CI 0.57-0.66) when call hospital interval was there was over 60 minutes. Methods of shortening the intervals from the initial request call to the first contact with an OHCA patient and arrival at a medical facility would contribute to improvement of social rehabilitation rate.

This study is limited by its observational nature. Further, the Utstein database does not contain diagnosis and the severity of a disease, which influences the prognosis of patients with OHCA. Lastly, we do not assess socioeconomic status such as education, income, and general accessibility to medical services, which has been previously reported as pertinent to this kind of analysis [11].
Conclusion

In conclusion, we found that social rehabilitation following OHCA is worse when the event occurs during the night, additionally AED use remarkably improves social rehabilitation rate.

Competing Interests

The authors declare that they have no competing interests.

References


This article was originally published in a special issue:
Various Approaches for Rehabilitation Science
Handled by Editor(s):
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