A Double-Edged Sword: Neurologic Complications and Mortality in Extracorporeal Membrane Oxygenation Therapy for COVID-19–Related Severe Acute Respiratory Distress Syndrome at a Tertiary Care Center

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ABSTRACT

SUMMARY: In this clinical case series, we report our experience to date with neurologic complications of extracorporeal membrane oxygenation therapy for COVID-19 Acute Respiratory Distress Syndrome. We have found an unexpectedly increased rate of complications as demonstrated by neuroimaging compared with meta-analysis data in extracorporeal membrane oxygenation therapy for all Acute Respiratory Distress Syndrome etiologies over the past few decades and compared with the most recent baseline data describing the incidence of neurologic complication in all patients with COVID-19. For our 12-patient cohort, there was a rate of intracranial hemorrhage of 41.7%. Representative cases and images of devastating intracranial hemorrhage are presented. We hypothesize that the interplay between hematologic changes inherent to extracorporeal membrane oxygenation and inflammatory and coagulopathic changes that have begun to be elucidated as part of the COVID-19 disease process are responsible. Continued analysis of extracorporeal membrane oxygenation therapy in this disease paradigm is warranted.

ABBREVIATIONS: ARDS = Acute Respiratory Distress Syndrome; COVID-19 = coronavirus disease 2019; ECMO = extracorporeal membrane oxygenation; MERS = Middle East respiratory syndrome; vv = venovenous
admitted patients who are positive for COVID-19.⁷ Although there are small case series in the literature regarding ECMO therapy and intracranial hemorrhage in patients with COVID-19,⁸ the data regarding ECMO therapy as it relates to the neurologic sequelae and outcomes of COVID-19 remain sparse. Our larger case series aims to elucidate this relationship.

MATERIALS AND METHODS
An observational study design was performed with approval from our institutional review board. The number of inpatients admitted to a tertiary health care system between March 1, 2020, and May 19, 2020, with confirmed infection status of “COVID-19 positive” was determined by using the “Reports” function of the electronic medical record system (Epic Systems). A list of inpatients with an infection status of “COVID-19 positive” and with neuroimaging of the head performed during the same time period, including CT/CTA and MRI/MRA, was subsequently generated.

The medical records of these participants were examined, and the age, sex, utilization of ECMO, either venovenous (VV) or venoarterial, and duration of ECMO therapy during their admissions were recorded. The rationale for initiation of ECMO in these patients was at the discretion of the treating pulmonologist and according to institutional guidelines. The presence of potentially contributory medical comorbidities in this cohort, including autoimmune conditions, immunosuppression, hypertension, diabetes mellitus, asthma, and structural lung disease, was documented. Additionally, the anticoagulation method used during ECMO as well as the patients’ platelet counts at the time of imaging were recorded.

The clinical examination findings prompting neuroimaging in the ECMO cohort were recorded. The images and reports for patients on ECMO with brain imaging were reviewed for critical findings, which we defined as acute or subacute intracranial hemorrhage, acute or subacute infarction, vascular occlusion, findings of infection or inflammation, herniation, hydrocephalus, and evidence of hypoxic-ischemic encephalopathy.

RESULTS
Between March 1, 2020, and May 19, 2020, we identified 12 patients on VV-ECMO at the time of neuroimaging and none on VA-ECMO. The demographics, comorbidities, anticoagulation therapy, ECMO duration, platelet counts, clinical examination findings prompting neuroimaging, and imaging findings are all presented in the On-line Table.

The most common comorbid conditions in the cohort were hypertension (5 of 12; 41.7%), type 2 diabetes mellitus (4 of 12, 33%), and asthma (4 of 12, 33%). Additional pre-existing conditions that could have predisposed patients to vascular phenomena were present: 1 patient had systemic lupus erythematosus, another had sickle cell trait, and a third had rheumatoid arthritis.

The mean duration of ECMO therapy in our cohort at the time of imaging was 230.3 hours. This is similar to the duration of therapy in the referenced meta-analysis, in which the mean duration of therapy in both the CNS complication and non-CNS complication groups was approximately 258 hours.⁵

Critical findings meeting our criteria were identified on neuroimaging studies from 6 of the 12 (50%) participants on ECMO. The most common critical findings were intracranial hemorrhage (5 of 12; 41.7%) with associated herniation in 4 of 5 patients (Figs 1 and 2). All 5 patients had subarachnoid hemorrhage, 4 of 5 had intraparenchymal hemorrhage, and 3 of 5 had intraventricular hemorrhage (solid arrow).
hemorrhage. Evidence of ischemic infarctions were seen in 2 of 6, both with concomitant intracranial hemorrhage. Three patients had findings of hydrocephalus. All 4 patients with parenchymal hemorrhage and herniation seen on neuroimaging died from the complications. The fifth patient had isolated small-volume subarachnoid hemorrhage that subsequently resolved, but this patient died from ongoing respiratory complications. The sixth patient had findings suggestive of communicating hydrocephalus without a clear cause. One of the 12 patients had vascular imaging with CTA of the head and neck, which did show multiple intracranial large-vessel occlusions; this patient also had multicompartmental intracranial hemorrhages.

**DISCUSSION**

Our analysis of the subset of patients with COVID-19–related ARDS treated with ECMO at our institution demonstrates an unexpectedly increased rate (50%) of devastating neurologic events, specifically intracranial hemorrhage (41.7%), as demonstrated by emergently performed neuroimaging. Comparatively, a recent meta-analysis of patients treated with ECMO for respiratory failure from 1992 to 2015 showed a neurologic complication rate of 7.1%, including an incidence of cerebral hemorrhage of 3.6%. Furthermore, a recent similarly designed cohort study of 246 consecutive patients who were positive for COVID-19 with neuroimaging at a large tertiary care center showed an incidence of intracranial hemorrhage of 4.5%. Although the statistical significance of this difference cannot be definitely determined at this time, the results of our analysis do show a trend toward a significantly increased rate of devastating neurologic events manifested on neuroimaging.

Despite the mortality benefit of ECMO demonstrated in patients with MERS-CoV ARDS, we hypothesize that the interplay between the novel COVID-19–related coagulopathy, pre-existing conditions, and the hematologic alterations inherent to continuous VV-ECMO could be responsible for the increased risk of neurologic complications in this cohort. This is in keeping with similar mechanisms suggested in the most recent literature.

The main limitation of our analysis is the small sample size to date of patients at our institution treated with ECMO for COVID-19–related ARDS. Given the scope of the coronavirus pandemic and international expert predictions that outbreaks could be experienced for at least the next couple of years, an accelerated prospective clinical trial of the risk versus benefit of ECMO therapy in patients with COVID-19–related ARDS should be considered as feasible. Regardless, continuous retrospective analysis of the available data regarding all aspects of this treatment paradigm is warranted, such that future pooled analyses could add to our work and assess statistical significance of neurologic complications.

**CONCLUSIONS**

The evidence continues to mount that ECMO should be used with extreme caution in patients with COVID-19–related ARDS. Very close neurologic monitoring and a low threshold for neuroimaging in this cohort should be used because our findings show a concerning trend toward an increased rate of neurologic complications.

**REFERENCES**