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Background

There have been few studies on the relationship between serum chloride concentration and patients' prognosis in the Emergency Department(ED), diagnosed with septic shock. We hypothesized that higher chloride levels of patients with severe sepsis or septic shock are associated with higher mortality rates.

Patients & Methods

This retrospective observational study used data from a prospectively-collected multicenter ED based registry of the Korean Shock Society (KoSS), between October 2015 and April 2018. 21 tertiary level EDs were participated. The primary outcome was 28-day mortality rate.

Data collection

A case report form of the KoSS septic shock registry takes in standard definitions of 200 variables including baseline characteristics, co-morbidities, therapeutic interventions and outcomes of septic shock patients.







Results & Discussion

Patients were divided into three groups according to the initial serum chloride concentration:

> Hypochloremia < 98 mEq/L Normochloremia 98-110mEq/L Hyperchloremia > 110 mEq/L

The 28-day mortality rate was most highly reported in hyperchloremic group.

> hypochloremia vs. normal vs. hyperchloremia 23.8% vs. 19.2% vs. 34.7%, P-value < 0.001

After adjusted for confounding variables in multivariate logistic regression analysis; age, gender, acid-base state, SOFA score, and lactate levels, the 28-day mortality risk was significantly increased in hyperchloremic group (Adjusted OR 1.65, 95% CI 1.0-2.7; P-value 0.04) and hypochloremia group (Adjusted OR 1.3, 95% CI 1.02-1.67; P-value 0.04).

Subgroup analysis was performed by the acid-base state. Adjusted ORs for 28-day mortality was significantly increased in the hypochloremia group(Adjusted OR 1.84 95% CI 1.13-3.01; P-value 0.01) but not in the hyperchloremia group (Adjusted OR 1.08, 95% CI 0.49-2.39; P-value 0.85).

Conclusion & Perspectives

We found out that hypochloremia is a fatal risk factor for severe sepsis or septic shock patients, even after adjusting for Subgroup analysis also revealed confounders. that hypochloremia is a significant risk factor, especially in the septic shock patient with acidosis. It can be explained considering the fact that hypochloremia induces metabolic alkalosis to compensate for the acidic state such as lactic acidosis.

Hypochloremia is associated with mortality in septic shock: a secondary analysis of a multicenter prospective registry.

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Figure 2. Main results of multivariable logistic regression analysis.

	Adjusted of		
Age per 10 increment			
(Gender)			
- male			
- female			
- Terriale			
<i></i>			
(Acid-base)			
- acidosis			
- normal			
- alkalosis			
anarono			
(Chlorida)			
- hypochloremia			
nypeennerenna			
- normal			
- normar			
- hyperchloremia			
Lactate per 1 increment			
Maximum SOFA score per 1 increment			

Table 1. Subgroup analysis based on acid-base state.

Variable	Subgroup	OR	Lower Cl	Upper Cl	P-value
hypochloremia	acidosis	1.84	1.13	3.01	0.014
	normal pH	1.23	0.8	1.88	0.351
	alkalosis	1.13	0.76	1.67	0.550
hyperchloremia	acidosis	1.08	0.49	2.39	0.855
	normal pH	2.14	1.01	4.57	0.048
	alkalosis	2.26	0.79	6.43	0.126

Table 2. Baseline characteristics, clinical and outcome variables.

Variable	hypochloremia(< 98 mEq/L)	normal(98-110 mEq/L)	hyperchloremia(>110 mEq/L)		p-
	(37.3%. n=760)	(58.01%. n=1182)	(4.6%. n=95)	Total (n=2037)	value
Age. vear	65.9 ± 13.3	68.7 ± 13.3	72.0 ± 12.8	67.8 ± 13.4	0.000
Male. %	453 (59.61%)	705 (59.64%)	48 (50.53%)	1206 (59.20%)	0.211
Systolic blood pressure, mmHg	97.71 ± 28.04	100.34 ± 30.53	96.03 ± 29.31	99.16 ± 29.59	0.092
Diastolic blood pressure, mmHg	59.56 ± 18.96	60.59 ± 19.22	59.23 ± 20.60	60.14 ± 19.19	0.457
Hypertension, %	296 (38.95%)	507 (42.89%)	41 (43.16%)	844 (41.43%)	0.213
Diabetes mellitus, %	250 (32.89%)	342 (28.93%)	34 (35.79%)	626 (30.73%)	0.100
Cardiovascular disease, %	100 (13.16%)	162 (13.71%)	11 (11.58%)	273 (13.40%)	0.817
Cerebrovascular disease, %	76 (10.00%)	147 (12.44%)	24 (25.26%)	247 (12.13%)	0.000
Chronic lung disease, %	71 (9.34%)	91 (7.70%)	2 (2.11%)	164 (8.05%)	0.040
Hematologic malignancy, %	58 (7.63%)	78 (6.60%)	6 (6.32%)	142 (6.97%)	0.661
Metastatic cancer, %	222 (29.21%)	236 (19.97%)	10 (10.53%)	468 (22.97%)	0.000
Chronic renal disease, %	58 (7.63%)	88 (7.45%)	15 (15.79%)	161 (7.90%)	0.014
Chronic liver disease, %	102 (13.42%)	129 (10.91%)	10 (10.53%)	241 (11.83%)	0.229
Dementia, %	24 (3.16%)	87 (7.36%)	12 (12.63%)	123 (6.04%)	0.000
Presence of transplanted organ, %	17 (2.24%)	18 (1.52%)	3 (3.16%)	38 (1.87%)	0.333
WBC * 10^3, mm^3	14.28 ± 21.89	12.55 ± 13.18	11.26 ± 8.26	13.13 ± 16.83	0.046
Neutrophil, %	76.25 ± 23.39	77.64 ± 21.79	77.72 ± 20.94	77.11 ± 22.38	0.417
Platelet, *10^3, mm^3	168.15 ± 124.10	163.23 ± 118.57	161.55 ± 104.18	164.99 ± 120.02	0.651
Sodium, mmol/L	130.57 ± 5.32	136.83 ± 4.14	145.41 ± 6.52	134.90 ± 6.06	0.000
Potassium, mmol/L	4.31 ± 0.89	4.18 ± 0.77	4.16 ± 1.12	4.23 ± 0.84	0.003
Chloride, mmol/L	92.79 ± 4.23	102.46 ± 3.35	114.99 ± 4.06	99.43 ± 6.86	0.000
Blood urea nitrogen, mg/dL	33.91 ± 21.96	31.07 ± 19.18	48.29 ± 32.94	32.94 ± 21.38	0.000
Creatinine, mg/dL	1.96 ± 1.67	1.68 ± 1.21	2.22 ± 2.21	1.81 ± 1.46	0.000
Albumin, g/dL	2.93 ± 0.67	2.99 ± 0.66	2.62 ± 0.65	2.95 ± 0.67	0.000
hs-CRP, mg/dL	16.47 ± 12.42	13.57 ± 12.48	13.76 ± 10.83	14.66 ± 12.46	0.000
Procalcitonin, ng/mL	27.21 ± 58.07	29.10 ± 64.97	22.00 ± 34.98	28.09 ± 61.42	0.584
pH	7.42 ± 0.12	7.41 ± 0.10	7.36 ± 0.13	7.41 ± 0.11	0.000
PCO2, mmHg	29.77 ± 12.12	29.36 ± 9.66	29.93 ± 11.54	29.54 ± 10.73	0.667
PO2, mmHg	85.80 ± 40.93	85.14 ± 41.34	94.46 ± 57.52	85.82 ± 42.10	0.116
Bicarbonate, mEq/L	19.59 ± 6.00	18.81 ± 4.90	16.96 ± 6.49	19.02 ± 5.44	0.000
SaO2, %	93.08 ± 9.32	92.98 ± 9.03	91.72 ± 10.06	92.96 ± 9.19	0.393
Lactate, mmol/L	4.59 ± 3.71	4.04 ± 3.00	3.96 ± 2.68	4.24 ± 3.28	0.001
Sequential organ failure assessment(SOFA)	8.51 ± 3.83	8.31 ± 3.80	10.05 ± 3.60	8.46 ± 3.81	0.000
Acute physiology and chronic health evaluation(APACHE)	21.09 ± 8.96	19.81 ± 9.10	23.87 ± 10.01	20.48 ± 9.14	0.000
28-day death, %	181 (23.82%)	227 (19.20%)	33 (34.74%)	441 (21.65%)	0.000



lds ratios for 28-day mortality

