Effect of temperature maintenance by forced-air warming blankets of different temperatures on changes in inflammatory factors in children undergoing congenital hip dislocation surgery

Li-Ping He, Pei-Zhen Liu, Yuan-Ming Wen, Jun Wu

Department of Operation Room, Guangzhou Women and Children’s Medical Center, Guangzhou Medical University, Guangzhou, Guangdong 510623, China.

Abstract
Background: Hypothermia is associated with many adverse clinical outcomes in pediatric patients, and thus, it is important to find an effective and safe method for preventing peri-operative hypothermia and its associated adverse outcomes in pediatric patients. This study aimed to investigate the effect of forced-air warming blankets with different temperatures on changes in the transforming growth factor-β (TGF-β), tumor necrosis factor (TNF)-α, interleukin (IL)-1β, and IL-10 levels in children undergoing surgical treatment for developmental displacement of the hip (DDH).

Methods: The study included 123 children undergoing surgery for DDH under general anesthesia. The patients were randomly assigned to three groups, using a random number table: the 32, 38, and 43°C groups according to the temperature setting of the forced-air warming blankets. For each patient, body temperature was recorded immediately after anesthesia induction and intubation (T0), at initial incision (T1), at 1 h after incision (T2), at 2 h after incision (T3), at the end of surgery (T4), immediately upon return to the ward after surgery (T5), and then at 12 h (T6), 24 h (T7), 36 h (T8), and 48 h (T9) after the surgery. The serum levels of TGF-β, TNF-α, IL-1β, and IL-10 were measured at T0 and T4 for all groups.

Results: The number of patients with fever in the 38°C group was significantly less than those in the 32 and 43°C groups (χ² = 6.630, P = 0.036). At T0, the body temperatures in the 38 and 43°C groups were significantly higher than that in the 32°C group (F = 17.992, P < 0.001). At T2, the body temperature was significantly higher in the 43°C group than those in the 32 and 38°C groups (F = 12.776, P < 0.001). Moreover, at T4, the serum levels of TGF-β (F = 3286.548, P < 0.001) and IL-10 (F = 4628.983, P < 0.001) were significantly increased in the 38°C group, and the serum levels of TNF-α (F = 911.415, P < 0.001) and IL-1β (F = 322.191, P < 0.001) were significantly decreased in the 38°C group, compared with the levels in the 32 and 43°C groups.

Conclusion: Force-air warming blankets set at 38°C maintained stable body temperature with less adverse outcome and effectively inhibited the inflammatory response in pediatric patients undergoing surgery for DDH.

Clinical trial registration: ChiCTR1800014820; http://www.chictr.org.cn/showproj.aspx?proj=25240.

Keywords: Body temperature; Developmental displacement of the hip; Inflammatory factor; Rehabilitation; Transforming growth factor-beta.

Introduction
Hypothermia, defined as a core temperature <36.7°C, frequently occurs in the peri-operative period, especially in infants and young children. Peri-operative hypothermia can be caused by a large surgical wound, great blood loss, long operative time, disrupted thermoregulation by anesthesia, and use of low-temperature fluids. Hypothermia is associated with many adverse clinical outcomes, such as infection, cardiovascular complications, increased length of hospital stay, metabolic dysfunction, and even death.[1] Therefore, it is important to find an effective and safe method for preventing peri-operative hypothermia and its associated adverse outcomes in pediatric patients.

Developmental displacement of the hip (DDH) is a common pediatric malformation characterized by displacement of the femoral head. Orthopedic surgery has been found to be effective and safe for the treatment of DDH in infants and young children.[2] Pediatric patients who undergo surgical treatment for DDH are prone to peri-operative hypothermia due to the large surgical wound and long operative time.[3] Forced-air warming is recognized as the most effective intra-operative thermal...
insulation method to prevent peri-operative hypothermia, and the recommended temperature for adult patients is 32 to 38°C. However, few studies have investigated the efficacy of forced-air warming at different temperatures in pediatric patients undergoing surgery to correct congenital hip dislocation.

Additionally, it has been reported that appropriate peri-operative thermal insulation can effectively inhibit systemic inflammatory responses in children. Our previous study showed that intra-operative thermal insulation can also effectively suppress stress-induced inflammation, thus improving the child’s prognosis. Moreover, Murata et al reported that changes in body temperature can affect activation of the transforming growth factor-β (TGF-β) signaling pathway, an anti-inflammatory cytokine pathway that regulates cell growth and differentiation. However, the effect of the temperature set by the forced-air warming device on the levels of TGF-β and other inflammatory factors remains unclear.

In the present study, we aimed to determine the effect of forced-air warming blankets set at different thermal insulation temperatures on the changes in body temperature and serum levels of TGF-β and other inflammatory factors in pediatric patients undergoing surgical correction of congenital hip dislocation.

Methods

Ethical approval

The Ethics Committee of the Guangzhou Women and Children’s Medical Center approved this study (No. 2017121407). The patients’ parents gave their informed consent before patients’ inclusion in the study.

Patients

This study included 123 children with DDH who underwent orthopedic surgery under general anesthesia. Inclusion criteria were as follows: age ranged from 2 to 7 years old; American Society of Anesthesiologists (ASA)-physical status I–II according to the ASA Physical Status Classification; and no pre-operative respiratory infection, and no abnormalities in routine blood and urine tests. The exclusion criteria were as follows: (1) pre-operative fever of unknown cause; (2) coagulation dysfunction; (3) congenital heart disease; (4) epilepsy; (5) communication or mental retardation; (6) developmental delay, obesity; (7) hypersensitivity to known drugs; (8) severe liver and kidney dysfunction; or (9) severe genetic and metabolic disease. All surgeries were performed by the same group of orthopedic surgeons, using the same surgical procedures.

Among these patients, some cases received acetabular osteotomy or femoral shortening, while others received acetabular osteotomy + femoral shortening. The surgical procedures were carried out according to textbook instructions. Five to six layers of Cellacast Active Cast (Lohmann & Rauscher Internation GmbH & Co., KG D-56579 Rengsdorf, Germany), which is made of polyester, were applied for all patients. To avoid the influence of surgery method on the results, patients were randomly assigned to three groups, using a random number table: the 32°C group (n = 42), the 38°C group (n = 42), and the 43°C group (n = 39). The intra-operative body temperature of patients in the 32, 38, and the 43°C groups was maintained using a disposable aseptic air heating blanket (model number: 700, Bair Hugger Company; St. Paul, Minnesota, USA) with the temperature set to 32, 38, or 43°C, respectively. The temperatures used in this study are safely used in the clinic. The heating blanket covered the entire body except for the operative site. Air was inflated into the blanket for heat insulation, and the temperature was set to 32, 38, or 43°C for children in the 32, 38, and 43°C groups, respectively. To prevent the effect of environmental changes on body temperature, the temperature of the operating room was adjusted to 23°C with a relative humidity of 40% to 50%.

Anesthesia and surgical procedures

All children were fasted for 4 to 8 h, and oral fluids were restricted for 3 to 6 h before surgery. Anesthesia was induced with intravenous injections of fentanyl, propofol, and rocuronium. After successful intubation, the endotracheal tube was fixed and connected to the anesthesia machine for mechanical ventilation, with a tidal volume of 8 to 12 mL/kg, a respiration frequency of 18 to 22 times/min, and an inspiration and expiration ratio of 1:1.5. After induction of anesthesia, central venous catheterization was performed through the right jugular vein and used for hydration and monitoring of venous pressure. After catheterization, the child was placed in a lateral position, and the operative site was disinfected. Anesthesia was maintained using inhalation of 1.5% to 2.5% sevoflurane, intravenous injection of remifentanil by a syringe pump with an initial rate of 0.2 μg/kg per min, and intermittent intravenous injection of vecuronium bromide for muscle relaxation. All the children were monitored with bispectral index and end-tidal carbon dioxide (ETCO2) at the end of expiration. The anesthesia depth was maintained between 40 and 60 during the operation. Respiratory parameters were adjusted to maintain ETCO2 at the end of expiration of 35 to 45 cm H2O. Real-time monitoring of direct arterial pressure and heart rate was performed to maintain the heart rate and blood pressure within 30% of the baseline values. After the operation, the endotracheal tube was removed once the children recovered autonomous respiration.

Clinical data collection

For each patient, the body temperature recorded immediately after anesthesia induction and intubation (T0), at initial incision (T1), at 1 h after incision (T2), at 2 h after incision (T3), at the end of surgery (T4), immediately upon return to the ward after surgery (T5), and then at 12 h (T6), 24 h (T7), 36 h (T8), and 48 h (T9) after the surgery. A body temperature probe was placed in the esophagus to measure the body temperature. The operative time, intra-operative blood loss, and intra-operative infusion volume were recorded during surgery. Post-operative fever (defined by an axillary temperature above 37.4°C and fluctuation >1°C within 1 day), hospitalization days, and wound infection (defined by the presence of exudation, rupture, and
suppuration of the incision under direct vision during dressing change) were noted. The body temperature at each time point was the main outcome index.

**Western blotting**

Venous blood (2 mL) was taken from each patient at T₀ and T₄. Blood samples were centrifuged at 4°C, and the serum was removed. Membranes were incubated with primary antibodies against TGF-β (sc-133216; rabbit anti-human TGF-β antibodies, dilution l:5000, Santa Cruz Biotechnology, Dallas, Texas, USA) at 4°C overnight. glyceraldehyde-3-phosphate dehydrogenase (GAPDH) was used as a loading control. Membranes were then incubated with horseradish peroxidase-linked goat anti-rabbit secondary antibodies (1:3000, Santa Cruz Biotechnology) at 37°C for 1 h. Bands were visualized using a chemiluminescence detection system. The relative expression of TGF-β was normalized to GAPDH expression.

**Enzyme-linked immunosorbent assay (ELISA) analysis**

The serum levels of tumor necrosis factor (TNF)-α, interleukin (IL)-1β, and IL-10 were determined by ELISA (Wuhan BOSTER, China). Briefly, 2 mL of venous blood was taken at T₀ and T₄. The blood samples were centrifuged at 4°C, and the supernatant was removed and analyzed using an ELISA kit according to the manufacturer’s instructions. The absorbance value was measured using an iMark ELISA device (model: iMark, Bio-Rad Company, Hercules, California, USA) at the wavelength of 490 nm.

**Primary and secondary outcome measures**

The primary outcome measure was the body temperature at each time point. The secondary outcome measure was the inflammatory factors in T₀ and T₄. Both primary and secondary outcome measures were recorded by a researcher blinded to the experimental conditions.

**Sample size determination**

The formula used to determine the number of samples compared by multiple sample rates was:

\[ n = \frac{2\lambda}{(2\sin^{-1}\sqrt{P_{max}} - 2\sin^{-1}\sqrt{P_{min}})^2} \]

Where \( \lambda = 0.05 \) and \( \beta = 0.1 \), and \( P_{max} \) and \( P_{min} \) are the maximum rate and the minimum rate, respectively. According to literature reports, with \( P_{max} = 0.27, P_{min} = 0.02, \) and \( \lambda_0.05 \cdot 0.1 = 1.26 \) substituted into the formula above, \( n = 39 \) can be obtained. Thus, a total of 117 cases were needed in the three groups.

**Statistical analysis**

Statistical analyses were performed using SPSS 21.0 software (SPSS Inc., Chicago, IL, USA). Quantitative data are expressed as the mean and standard deviation of the normal distribution. One-way analysis of variance was used to compare the difference among groups followed by post-hoc least significant difference method. Categorical data were analyzed using the Chi-square test. \( P < 0.05 \) was considered to be statistically significant.

**Results**

**Clinical characteristics of patients**

Table 1 summarizes the clinical characteristics of patients in the 32, 38, and 43°C groups. There were no statistically significant differences in age, body weight, gender ratio, operative time, intra-operative blood loss, intra-operative rehydration, post-operative hospitalization days, and wound infection among the three groups (\( P > 0.05 \)). The number of patients with fever in the 38°C group was significantly less than those in the 32 and 43°C groups (\( \chi^2 = 6.630, P = 0.036 \)).

| Table 1: Clinical characteristics of 123 children undergoing surgery for developmental displacement of the hip under general anesthesia in the three groups. |
|-----------------------------------------------|
| Items                              | 32°C group (n = 42) | 38°C group (n = 42) | 43°C group (n = 39) | \( \chi^2 \) | P     |
| Age (years)                        | 4.76 ± 1.72        | 5.38 ± 2.26        | 4.92 ± 2.92        | 0.789 *       | 0.454 |
| Body weight (kg)                   | 13.32 ± 4.30       | 14.41 ± 4.39       | 14.01 ± 5.72       | 0.552 *       | 0.759 |
| Gender ratio (male/female)         | 9/33               | 10/32              | 8/31               | 0.138 *       | 0.933 |
| Operative time (min)               | 235.00 (106.25)    | 244.00 (103.00)    | 220.00 (143.00)    | 1.855 *       | 0.395 |
| Intra-operative blood loss (mL)    | 231.50 (207.25)    | 189.00 (207.75)    | 231.00 (193.00)    | 1.989 *       | 0.370 |
| Intra-operative rehydration (mL)   | 904.50 (560.50)    | 931.50 (534.50)    | 1004.00 (619.00)   | 0.921 *       | 0.631 |
| Fever (n)                          | 7                  | 1                  | 8                  | 6.630 *       | 0.036 |
| Post-operative hospitalization days (days) | 3.41 ± 0.90       | 3.79 ± 1.21        | 3.72 ± 1.11        | 1.460 *       | 0.236 |
| Wound infection (n)                | 0                  | 0                  | 0                  | 0.000 *       | 1.000 |
| Chills (n)                         | 2                  | 2                  | 1                  | 0.358 *       | 0.836 |
| Acetabular osteotomy (n)           | 21                 | 22                 | 20                 | 0.048 *       | 0.976 |
| Femoral shortening (n)             | 1                  | 1                  | 1                  | 0.004 *       | 0.998 |
| Acetabular osteotomy + femoral shortening (n) | 20                | 19                 | 18                 | 0.049 *       | 0.976 |
| Extubation time (min)              | 21.32 ± 1.82       | 22.08 ± 2.15       | 21.63 ± 1.99       | 1.545 *       | 0.217 |
| Awaking time (min)                 | 74.39 ± 8.44       | 74.20 ± 6.13       | 75.17 ± 5.93       | 0.301 *       | 0.744 |

Data are expressed as mean ± standard deviation or median (interquartile range). * \( F \) value. † \( \chi^2 \) value.

www.cmj.org
Body temperature

Within each group, the body temperature of patients was significantly increased at T1 to T4 compared with that at T0 and remained within the normal range [Figure 1A], suggesting that the heating temperatures of 32, 38, and 43°C prevented hypothermia during the operation. At T0, the body temperatures in the 38 and 43°C groups were significantly higher than that in the 32°C group (F = 17.992, P < 0.001). At T3, the body temperature was significantly higher in the 38 and 43°C groups than in the 32 and 38°C groups (F = 12.776, P < 0.001). At T4, the body temperature appeared higher in the 38°C group than in the 32 and 43°C groups, although no significant difference was found. Furthermore, within each group, the body temperature was not significantly different among different time points, and at T5 to T9 each time point, the body temperature was not significantly different among the three groups (P > 0.05) [Figure 1B].

Serum levels of inflammatory factors

We examined the serum levels of TGF-β, TNF-α, IL-1β, and IL-10 at T0 and T4 in the 32, 38, and 43°C groups. At T0, there were no statistically significant differences in the serum levels TGF-β (F = 2.943, P = 0.057), TNF-α (F = 2.381, P = 0.097), IL-1β (F = 1.862, P = 0.161), and IL-10 (F = 2.459, P = 0.090) among the three groups [Figure 2]. At T4, the serum levels of TGF-β (F = 3286.548, P < 0.001) and IL-10 (F = 4628.983, P < 0.001) were significantly increased in the 38°C group, and the serum levels of TNF-α (F = 911.415, P < 0.001) and IL-1β (F = 322.191, P < 0.001) were significantly decreased in the 38°C group, compared with the levels in the 32 and 43°C groups [Figure 2].

Discussion

In this study, we investigated the effect of different temperatures set by forced-air warming blankets on changes in body temperature and the serum levels of inflammatory factors in pediatric patients undergoing surgery for DDH. We found that the temperature of 38°C was best for maintaining stable body temperature with fewer adverse post-operative outcomes. In addition, compared with those in the 32 and 43°C groups, the serum levels of TGF-β and IL-10 were significantly increased, and the serum levels of TNF-α and IL-1β were significantly decreased in the 38°C group. Our findings suggest that a forced-air warming blanket should be set at the temperature of 38°C to reduce hypothermia in pediatric patients undergoing surgery for DDH.

The incidence of intra-operative hypothermia is 43.9% for hip arthroplasty. Frisch et al.[12] retrospectively reviewed clinical data derived from 1541 patients with hip fracture and found that the risk of deep surgical-site infection was increased in patients who developed hypothermia. Surgical correction of pediatric DDH can cause post-operative hypothermia due to the large exposed body surface; extensive bleeding from the bone, muscle, and other tissues; great intra-operative blood loss; relatively large rehydration volume; long operative duration; and large internal exposure area in the operative field.[14] Accordingly, special attention to pediatric temperature management is required during hip dislocation surgery. Previous research indicated that the risk of hypothermia can be decreased in patients by elevating the ambient temperature to 26°C[15] and suggested that control of the temperature in the operation room might be the most efficient strategy for maintaining the body temperature of children. In this study, we found that forced-air warming blankets set at 32, 38, or 43°C maintained the body temperature in a normal range during the entire operation in children undergoing surgery for DDH. The 32, 38, and 43°C temperature management temperatures selected in this study were chosen based on the three gears provided by the inflatable heating blanket. However, compared with that in the 32°C group, the body temperature was more stable in the 38°C group [Figure 1], which is consistent with the report by Ge et al.[16] for abdominal surgery. Compared with that in the 38°C group, the body temperature in the 43°C group increased rapidly at T2 and T3 and then decreased more quickly to a level below that in the 38°C group at T4. The lower body
temperature in the 43°C group may be due to increased perspiration and that over-inhalation of warmed air triggers a negative feedback regulation after the rapid increase in body temperature seen at T2 to T3. Therefore, gradual changes in the body temperature, even in children with hypothermia, are appropriate, and the forced-air warming blanket should be set at the temperature of 38°C to maintain a stable body temperature.

Good control of intra-operative body temperature can promote post-operative rehabilitation.[17] Qin et al.[18] reported that hypothermia due to poor thermal control aggravates the early inflammatory reaction after surgical trauma and is associated with poor prognosis. In this study, we found that although the body temperature can be maintained in the normal range by the use of forced-air warming blankets at temperatures of 32, 38, and 43°C, the temperature of 38°C rapidly corrected hypothermia during anesthesia induction and maintained more stable body temperature. In addition, at T4, the serum levels of TGF-β and IL-10 were significantly higher and the serum levels of TNF-α and IL-1β were significantly lower in the 38°C group compared with levels in the 32 and 43°C groups. TGF-β and IL-10 are anti-inflammatory cytokines that inhibit immune function and suppress inflammation,[9,19] whereas TNF-α and IL-1β are pro-inflammatory cytokines that induce inflammation.[20] Our findings suggest that a forced-air warming blanket set at the temperature of 38°C may produce an anti-inflammatory effect, which may explain the reduced incidence of post-operative fever in the 38°C group.

Changes in the serum level of inflammatory cytokines are sensitive indicators of the stress response in children[21] and are affected by various factors including pain, blood loss, hypothermia, and operative duration.[22] It has been shown that activation of the TGF-β signaling pathway is regulated by temperature.[23,24] Consistent with these findings, we found that the serum level of TGF-β was higher in the 38°C group than in the 32 and 43°C groups. This may be because 38°C, the temperature closest to a child’s physiologic temperature, resulted in balanced metabolism, which promoted the activation of TGF-β. In summary, we found that use of a forced-air warming blanket set at the temperature of 38°C maintained a stable body temperature with a reduced incidence of post-operative fever in pediatric patients undergoing surgery for DDH. The serum levels of the anti-inflammatory cytokines TGF-β and IL-10 were increased and those of the pro-inflammatory cytokines TNF-α and IL-1β were decreased in patients treated with a forced-air warming blanket set at the temperature of 38°C. Our findings suggest that a forced-air warming blanket set at the temperature of 38°C should be used to prevent hypothermia in pediatric patients undergoing surgery for DDH.
In conclusions, force-air warming blankets set at 38°C maintained stable body temperature with less adverse outcome and effectively inhibited the inflammatory response in pediatric patients undergoing surgery for DDH.

**Funding**

This work was supported by grants from the Guangzhou Institute of Pediatrics/Guangzhou Women and Children’s Medical Center (No. YIP-2018-037 and YIP-2019-061).

**Conflicts of interest**

None.

**References**

1. Menzel M, Grote R, Leuchtmann D, Lautenschlager C, Roseler C, Brauer A. Implementation of a thermal management concept to prevent perioperative hypothermia: results of a 6-month period in clinical practice. Anaesthetist 2016;65:423–429. doi: 10.1007/s00101-016-1058-8.

2. Terjesen T. Dysplasia of the contralateral hip in patients with unilateral late-detected congenital dislocation of the hip: 50 years’ follow-up of 48 patients. Bone Joint J 2014;96-b:1161–1166. doi: 10.1302/0301-620X.96B9.33768.

3. Zhao BS, Xing XR, Tan YH. Application of mistral air inflatable heating device in postoperative insulation for in children with congenital hip dislocation (in Chinese). Chin J Nurs Res 2015;29:977–980. doi: 10.17305/bjbms.2018.2552.

4. Alderson P, Campbell G, Smith AF, Warttig S, Nicholson A, Lewis SR. Thermal insulation for preventing inadvertent perioperative hypothermia. Cochrane Database Syst Rev 2014;4:166–172. doi: 10.1002/14651858.CD009908.pub2.

5. Horn EP, Ben B, Steinfath M, Ramaker K, Buchholz B, Hocker J. The incidence and prevention of hypothermia in newborns before cesarean delivery: a randomized controlled trial. Anesth Analg 2014;118:997–1002. doi: 10.1213/ANE.0000000000000160.

6. Perl T, Peichl LH, Reyntjens K, Deblaere I, Zaballos JM, Brauer A. Efficacy of a novel prewarming system in the prevention of perioperative hypothermia. A prospective, randomized, multicenter study. Minerva Anestesiol 2014;80:436–443. doi: 10.1097/ SHK.0000000000000147.

7. He LP, Liu PZ. Influences of thermal insulation of different temperatures on the changes of inflammatory response and postoperative rehabilitation in children with congenital dislocation hip surgery (in Chinese). Chin J Nurs 2017;52:1047–1051. doi: 10.3761/j.issn.0254-1769.2017.09.005.

8. Mortzfeld BM, Taubenheim J, Klimovich AV, Fraume S, Rosenstiel P, Bosch TCG. Temperature and insulin signaling regulate body size in Hydra by the Wnt and TGF-beta pathways. Nat Commun 2019;10:3257. doi: 10.1038/s41467-019-11316-6.

9. Kurebayashi Y, Baba Y, Minowa A, Nadya NA, Azuma M, Yoshimura A, et al. TGF-beta-induced phosphorylation of Akt and Foxo transcription factors negatively regulates induced regulatory T cell differentiation. Biochem Biophys Res Commun 2016;480:114–119. doi: 10.1016/j.bbrc.2016.09.153.

10. Liu J, Yu B. Anesthesiology. Beijing, China: People’s Medical Publishing House; 2014.

11. Pan SC. Practice of Pediatric Orthopedics (Chapter Seven). Beijing, China: People’s Medical Publishing House; 2016.

12. Frisch NB, Pepper AM, Rooney E, Silvertown C. Intraoperative hypothermia in total hip and knee arthroplasty. Orthopedics 2017;40:56–63. doi: 10.3928/01477447-20161017-04.

13. Frisch NB, Pepper AM, Jildeh TR, Shaw J, Guthrie T, Silvertown C. Intraoperative hypothermia during surgical fixation of hip fractures. Orthopedics 2016;39:e1170–e1177. doi: 10.3928/01477447-20160814-04.

14. Torossian A, Brauer A, Hocker J, Bein B, Wolff H, Horn EP. Preventing inadvertent perioperative hypothermia. Dtsch Arztebl Int 2015;112:166–172. doi: 10.3238/arztebl.2015.0166.

15. Andrews P, Toossi S, Kanz M, Jackson TC. Perspectives on temperature management. Ther Hypothermia Temp Manag 2019;9:98–101. doi: 10.1089/ther.2019.29061.ppa.

16. Jin G, Liu Y, Liu J. The effects of three grades of heat preservation on infants temperature changes during abdominal surgery (in Chinese). Chin J Nurs 2016;51:583–586. doi: 10.3761/jissn.0254-1769.201605.014.

17. Bindu B, Bindra A, Rath G. Temperature management under general anesthesia: compulsion or option. J Anaesthesiol Clin Pharmacol 2017;33:306–316. doi: 10.4103/jacp.JACP_334_16.

18. Qin J, Mai Y, Li Y, Jiang Z, Gao Y. Effect of mild hypothermia preconditioning against low temperature (4 degrees C) induced rat liver cell injury in vitro. PLoS One 2017;12:e0176652. doi: 10.1371/journal.pone.0176652.

19. Wang Y, Sun L, Song Z, Wang D, Bao Y, Li Y. Maspin inhibits macrophage phagocytosis and enhances inflammatory cytokine production via activation of NF-kappB signaling. Mol Immunol 2017;82:94–103. doi: 10.1016/j.molimm.2016.12.021.

20. Zhao B, Pan Y, Xu H, Song X. Hyperbaric oxygen attenuates neuropathic pain and reverses inflammatory signaling likely via the Kindlin-1/Wnt-10a signaling pathway in the chronic pain injury model in rats. J Headache Pain 2017;18:1–8. doi: 10.1186/s10194-016-0713-y.

21. Schneider T, Sevko C, Ueppsl C, Beckhove P, Dieneemann H, et al. Serum inflammatory factors and circulating immunosuppressive cells are predictive markers for efficacy of radiofrequency ablation in non-small-cell lung cancer. Clin Exp Immunol 2015;180:467–474. doi: 10.1111/cei.12396.

22. Kuwahara E, Murakami Y, Okamura T, Komatsu H, Nakazawa A, Ushiku H, et al. TGF-beta-induced phosphorylation of Akt and Foxo transcription factors negatively regulates induced regulatory T cell differentiation. Biochem Biophys Res Commun 2016;480:114–119. doi: 10.1016/j.bbrc.2016.09.153.

23. Frisch NB, Pepper AM, Rooney E, Silvertown C. Intraoperative hypothermia in total hip and knee arthroplasty. Orthopedics 2017;40:56–63. doi: 10.3928/01477447-20161017-04.

24. Chen FL, Zhuang MK, Peng J, Wang XZ, Huang TX, Li SM, et al. Increased childhood BMI is associated with young adult serum uric acid levels: a linkage study from Japan. Pediatr Res 2017;81:293–298. doi: 10.1038/pr.2016.213.

25. Shao L, Fang NN, Yan P, Ju FJ, Sun Q, Ma WJ, et al. Control of body temperature and immune function in patients undergoing open surgery for gastric cancer. Bosn J Basic Med Sci 2018;18:289–296. doi: 10.17305/bjms.2018.2552.

26. Chen FL, Zhuang MK, Peng J, Wang XZ, Huang TX, Li SM, et al. Basal cell carcinoma inhibits migration and invasion of gastric cancer cells through suppression of the TGF-beta signaling pathway. Mol Med Rep 2014;10:1999–2003. doi: 10.3892/mmr.2014.2452.

How to cite this article: He LP, Liu PZ, Wen YM, Wu J. Effect of temperature maintenance by forced-air warming blankets of different temperatures on changes in inflammatory factors in children undergoing congenital hip dislocation surgery. Chin Med J 2020;133:1768–1773. doi: 10.1097/CM9.0000000000000846