Detecting central-venous oxygen desaturation without a central-venous catheter: utility of the difference between invasively and non-invasively measured blood pressure

Author(s)
Kumasawa, Junji

Citation
Kyoto University (京都大学)

Issue Date
2016-09-23

URL
https://dx.doi.org/10.14989/doctor.k19969

DOI: 10.1016/j.jcrc.2016.02.022

Type
Thesis or Dissertation

Textversion
ETD

Kyoto University
Detecting central-venous oxygen desaturation without a central-venous catheter: Utility of the difference between invasively and noninvasively measured blood pressure

Junji Kumasawa, MD a, b, *, Akitoshi Ohara, MD b, Hisakazu Kohata, MD b, Kenichi Aoyagi, MD b, Shingo Fukuma, PhD a, Shunichi Fukuhara, MD, DMS c, c

a Department of Healthcare Epidemiology, School of Public Health, Kyoto University Faculty of Medicine, Yoshidakonoe-cho, Sakyo-ku, Kyoto City, Japan 606-8315
b Department of Critical Care Medicine, Sakai City Medical Center, Ebara-jcho 1-1-1, Nishi-ku, Sakai City, Japan 593-8304
c Center for Innovative Research for Communities and Clinical Excellence, Fukushima Medical University, Hikarigaoka, Fukushima City, Japan 960-1295

ARTICLE INFO

Keywords:
Blood pressure monitors
Sensitivity and specificity
ROC curve
Central-venous catheterization
Oximetry
Shock

ABSTRACT

Objective: The objective was to determine whether central-venous oxygen saturation (ScvO2 < 70%) can be detected from the difference between invasively and noninvasively measured systolic blood pressure (BP) (ie, ΔBP defined as arterial BP minus noninvasive BP).

Methods: This is a cross-sectional study at a single medical and surgical intensive care unit in Japan. All hypotensive patients admitted to intensive care unit were eligible. Arterial BP was measured via a radial-artery catheter, and noninvasive BP was measured via a brachial cuff. ScvO2 was measured by gas analysis of blood sampled from a central-venous catheter (CVC). We calculate the area under the curve for ΔBP as an indicator of ScvO2 < 70%.

Results: Usable data were obtained from the records of 111 patients. The median and interquartile range of ΔBP and ScvO2 were −4 mm Hg (−11, 6) and 67% (60.9, 73.9), respectively. The area under the curve of ΔBP as an indicator of ScvO2 < 70% was 0.81 (95% confidence interval [CI], 0.73-0.89). With a cutoff ΔBP of 0, sensitivity was 65.7% (95% CI, 53.1-76.8); specificity was 97.7% (95% CI, 88.0-99.8), and positive predictive value was 97.8 (95% CI, 88.2-99.9).

Conclusions: ΔBP can indicate whether ScvO2 is lower than 70%. When that difference is greater than 0, ScvO2 is very likely to be lower than 70%.

© 2016 Elsevier Inc. All rights reserved.

1. Introduction

In recent large randomized trials of treatments of sepsis, therapy guided by measured values of central-venous oxygen saturation (ScvO2) did not reduce all-cause mortality [1–4]. However, in the treatment of critically ill patients, ScvO2 is still used as a prognostic marker, with values less than 70% indicating a poor prognosis, and it is also used to guide fluid therapy [5,6–8]. In recent randomized controlled trials, ScvO2-guided fluid therapy reduced perioperative complications.

ScvO2 reflects the balance between oxygen delivery and consumption and is used as a surrogate marker of cardiac output [9,10]. It is widely considered to be important for evaluating hemodynamic stability [5].

However, measuring ScvO2 requires a central-venous catheter either for repeated blood sampling or for continuous monitoring via a costly device. In addition to its unavoidable costs, central-venous catheterization carries risks of complications that, although infrequent, can be fatal [11,12]. Less invasive and costly methods of obtaining variables about oxygen delivery are needed [13]. Here we present a study of one such less invasive method.

Compared with central-venous catheterization, blood-pressure monitoring is safer, relatively inexpensive, and more commonly used in managing hemodynamically unstable patients. Two frequently used methods are to monitor blood pressure via an arterial catheter (invasively measured arterial blood pressure [ABP]) [14] and oscillometric noninvasive measurement (NIBP) [15]. Discrepancies between ABP at radial and NIBP at brachial have been found in patients with septic shock and in those who are hypotensive and under general anesthesia [16–23]. Although there are no previous published study which reports the relationship between this discrepancy and ScvO2, we presented at the 44th Critical Care Congress (Phoenix, AZ) that, in patients with hypotension, the discrepancy between systolic ABP at
radial and systolic NIBP at brachial was negatively associated with ScvO₂; correlation coefficient was 0.67 (95% confidence interval [CI], 0.38–0.84). If that association between ScvO₂ and the ABPs—NIBPs difference is strong, then the latter index, which can be obtained simply and inexpensively, can be used instead of ScvO₂. We evaluated the ABPs—NIBPs difference as an indicator of central-venous oxygen desaturation (ScvO₂ < 70%) in patients with hypotension.

2. Materials and methods

2.1. Design and setting

We retrospectively reviewed the medical records of adults with hypotension who were admitted to the intensive care unit (ICU) of Sakai City Medical Center (a tertiary center in Osaka, Japan), which has 8 beds and any medical patients and surgical patients except cardiac surgical patients are admitted to, between July 2013 and June 2015. This study was approved by the Institutional Review Boards at Sakai City Medical Center and Kyoto University.

2.2. Participants

We examined the records of all patients who were 18 years old or older and were admitted to the ICU at Sakai City Medical Center during the study period. We defined hypotension as ABPs < 90 mm Hg, and we analyzed data from all adults who were in hypotension at the time of ICU admission and whose ABP, NIBP, and ScvO₂ were simultaneously recorded.

2.3. Measurements

Arterial blood pressure was measured using a 20-gauge short Teflon catheter in a radial artery. The catheter was connected to a pressure transducer via 30 cm of noncompliant extension tubing with a continuous-flush device. The pressure transducer system was connected to a bedside monitor (IntelliVue MX800, Philips, Andover, Massachusetts, USA) to display the arterial waveform and systolic, diastolic, and mean arterial pressures. The transducer was zeroed to atmospheric pressure and referenced to the midaxillary line with the patient in the supine position. On the same side as the radial-artery catheter, noninvasively measured brachial blood pressure (NIBP) was measured by oscillography with a brachial cuff. The size of the cuff was chosen according to recent guidelines [24]. Both ABP and NIBP were displayed on a bedside monitor (IntelliVue MX800, Philips) and were recorded simultaneously.

Central-venous oxygen saturation was measured by analysis of blood sampled from a central-venous catheter. As a usual practice, the central-venous catheter (CVC) tip was positioned in superior vena cava. To ensure the optimal placement of the CVC tip, each physician who performed CVC insertion confirmed that the position of the CVC tip was positioned above the tracheal carina level by chest radiograph [25–27]. The blood samples were analyzed with a GEM Premier 3000 blood gas/electrolyte analyzer. Blood pressure and ScvO₂ were measured at the same times. The data analyzed here were blood pressure and ScvO₂ value at the first time when ScvO₂ was measured after admission to the ICU. Blood pressure and ScvO₂ data were collected during periods of hemodynamic stability to avoid wide fluctuations in blood pressure. We use “ΔBP” to refer to the difference between ABPs and NIBPs (ie, ABPs minus NIBPs).

We also recorded each patient’s age, sex, cause of admission, heart rate, blood pressure (systolic, diastolic, and mean, from both invasive and noninvasive measurements), use of mechanical ventilation, Acute Physiology and Chronic Health Evaluation II score, Sequential Organ Failure Assessment score, hemoglobin level, arterial blood oxygen saturation, and lactate level.

2.4. Statistical analysis

Continuous variables normally distributed are presented as means and SDs and compared by the t test. Continuous variables which are not distributed normally are presented as median, first quartile, and third quartile and compared by Mann-Whitney U test. Shapiro-Wilk test was performed to test for the data normality. Categorical variables are shown as absolute numbers with percentages. We calculated sensitivities, specificities, and the area under the receiver operating characteristic (ROC) curve for ΔBP as an indicator of ScvO₂ < 70%. Using the same analyses, we also examined ΔBP as an indicator of a more severe level of oxygen desaturation: ScvO₂ < 65%. To determine the optimal cutoff point for ΔBP, we used the Youden index, maximum

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Information on all adults admitted to the Intensive Care Unit with hypotension (ABPs &lt; 90 mm Hg) between July 2013 and June 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>n=64</td>
<td></td>
</tr>
</tbody>
</table>
| Age in years | 72 (57–81) | 67 (57–78) | .25
| Percent who were male | 59.5 | 59.3 | >.99
| Body mass index (SD) | 22.1 (3.9) | 21.5 (3.9) | .36
| Comorbidity | Diabetes | 29.7 | 17.2 | .07
| Hypertension | 44.1 | 29.7 | .07
| Dyslipidemia | 17.1 | 12.5 | .52
| Cause of ICU admission: Surgical | 5.4 | 68.8 | <.0001
| Percent surgical | 18.0 | 4.7 | .01
| Heart failure | 10/20 | 2/3 |
| Arrhythmia | 4/20 | 1/3 |
| ACS | 2/20 | 0 |
| Others | 4/20 | 0 |
| Percent Gr bleeding | 4.5 | 7.8 | .5
| Percent others | 16/2 | 13.2 | >.99
| ABPs, mm Hg | 82 (75–87) | 83 (79–88) | .20
| ABPd, mm Hg | 46 (40–53) | 48 (42–54) | .29
| ABPm, mm Hg | 59 (52.3–62.7) | 60 (55–64) | .13
| NIBPs, mm Hg | 83 (75–92) | 90 (80–95) | .007
| NIBPd, mm Hg | 50 (45–55) | 50 (45–59) | .23
| NIBPm, mm Hg | 61 (56–67) | 64 (57–71) | .04
| ΔBP, mm Hg | –4 (–11 to 6) | –8 (–12 to –1) | .06
| HR, beat/min | 95 (83–110) | 96 (81–113) | .61
| % ScvO₂ | 67.0 (60.9–73.9) | – |
| Hemoglobin, g/dL | 10.8 (9.3–12.4) | 10.6 (9.1–12.3) | .31
| % SaO₂ | 96.4 (94.6–98.7) | 98.0 (96.4–98.7) | <.0001
| Lactate, mmol/L | 2.1 (1.2–4.1) | 1.7 (0.9–2.6) | .01
| GI indicates gastrointestinal; ACS: acute coronary syndrome; ABPs: systolic invasive blood pressure; ABPd: diastolic invasive blood pressure; ABPm: mean invasive blood pressure; NIBPs: systolic noninvasive blood pressure; NIBPd: diastolic noninvasive blood pressure; NIBPm: mean noninvasive blood pressure; HR: heart rate; APACHE: Acute Physiology and Chronic Health Evaluation; SOFA: Sequential Organ Failure Assessment.

† Mann-Whitney U test.
‡ χ² test.
§ t test.
and third quartile values are zero. For whom ScvO2 data were not available were less severely ill, and a patients in this study, the median and interquartile range (IQR) of ABPs (75-92), the median and IQR of ScvO2 were 67.0% (60.9-73.9) (Table 1).

During the study period, 175 patients with hypotension were admitted to the ICU, and ScvO2 data were available for 111 of them. As an indicator of more severe desaturation (ScvO2 < 70%), the median and IQR of ΔBP were 4 mm Hg (−7 to 9), and among the patients with ScvO2 more than 70%, the median and IQR of ΔBP were −9 mm Hg (−14 to −5) (Table 2). According to the type of shock, the median and IQR of ΔBP were −7 mm Hg (−13 to −1) among patients with sepsis, 7 mm Hg (4-10) among patients with cardiogenic shock, and 5 mm Hg (−1 to 7) among patients with hypovolemic shock (Supplementary Fig. 1). Fig. 1 shows the ROC curve for ΔBP as an indicator of ScvO2 < 70%. The area under the curve was 0.81 (95% CI, 0.73-0.89).

Table 2 shows sensitivity, specificity, positive predictive value, and negative predictive value for ΔBP as an indicator of ScvO2 less than 70% at various cutoff values of ΔBP. With a cutoff ΔBP of 0 mm Hg, where Youden index was maximized (0.63), sensitivity was 65.7% (95% CI, 53.1-76.8), specificity was 97.7% (95% CI, 88.0-99.8), the positive predictive value was 97.8% (95% CI, 88.2-99.9), and the negative predictive value was 65.2% (95% CI, 52.4-76.5).

Central-venous oxygen saturation was less than 70% in 67 (60%) of the 111 patients. Among the patients with ScvO2 less than 70%, the median and IQR of ΔBP were 4 mm Hg (−7 to 9), and among the patients with ScvO2 more than 70%, the median and IQR of ΔBP were −9 mm Hg (−14 to −5) (Table 2). According to the type of shock, the median and IQR of ΔBP were −7 mm Hg (−13 to −1) among patients with sepsis, 7 mm Hg (4-10) among patients with cardiogenic shock, and 5 mm Hg (−1 to 7) among patients with hypovolemic shock (Supplementary Fig. 1). Fig. 1 shows the ROC curve for ΔBP as an indicator of ScvO2 < 70%. The area under the curve was 0.81 (95% CI, 0.73-0.89).

Table 2 shows sensitivity, specificity, positive predictive value, and negative predictive value for ΔBP as an indicator of ScvO2 less than 70% at various cutoff values of ΔBP. With a cutoff ΔBP of 0 mm Hg, where Youden index was maximized (0.63), sensitivity was 65.7% (95% CI, 53.1-76.8), specificity was 97.7% (95% CI, 88.0-99.8), the positive predictive value was 97.8% (95% CI, 88.2-99.9), and the negative predictive value was 65.2% (95% CI, 52.4-76.5).

Central-venous oxygen saturation was less than 65% in 44 (40%) of the 111 patients. As an indicator of more severe desaturation (ScvO2 < 65%), a ΔBP cutoff of 0 mm Hg was also excellent: sensitivity = 93.0%, specificity = 94.0%, and Youden index = 0.87 (Fig. 2 and Table 4).

4. Discussion

In patients with hypotension, a difference of 0 mm Hg or higher between systolic blood pressure measured invasively at radial and systolic blood pressure measured noninvasively at brachial was a very highly specific indicator of ScvO2 (~70%). Also, as an indicator of severe desaturation (ScvO2 < 65%), a difference of 0 mm Hg or higher between invasively and noninvasively measured systolic blood pressure was extremely sensitive and specific.

We are aware of no previous study of the relationship between ΔBP and ScvO2. Considering that ScvO2 is usually normal or high in patients with septic shock and it is usually low in patients with hemorrhagic shock, previous results regarding differences between ABP and NIBP are consistent with our findings that ΔBP is negative (ie, NIBPs > ABPs) when ScvO2 is greater than 70% and that ΔBP is positive (ie, NIBPs < ABPs) when ScvO2 is less than 70% [21,23,29].

Although the physiological mechanism underlying this phenomenon is unclear, we speculate that vascular resistance of the radial artery could cause this phenomenon. Rich et al [30] reported that the gradient between aortic pressure and radial pressure changed as vascular resistance of the radial artery changed during cardiac surgery. When vascular resistance increased, radial pressure increased and exceeded aortic pressure, and the opposite occurred when vascular resistance...
when systemic vascular resistance decreases, as it does in septic shock, radial artery pressure could decrease conversely. Conversely, when systemic vascular resistance increases, as it does in cardiogenic or hemorrhagic shock, then radial artery pressure could increase. Hatib et al. [31] reported that systolic arterial pressure increased from aorta to radial at normal hemodynamic and that this arterial pressure gradient was lost in animal models of endotoxic shock. They explained that this phenomenon was due to a differential effect of acute endotoxemia on the central- and peripheral-derived vascular compliance.

5. Limitations

This study has several limitations. First, because we relied on chart review, we cannot be sure about the validity and reliability of the blood pressure measurements. However, blood pressures were measured at the end of expiration during the period of hemodynamic stability to avoid wide fluctuations in blood pressure, as is our usual practice, and we believe that changes in systolic arterial pressure over those several seconds were within ± 3 to 5 mm Hg. As Table 2 shows, sensitivities and negative predictive values were very high at ΔBPs of 0 mm Hg and higher, and these values would not have been affected by measurement error of arterial pressure within 3 to 5 mm Hg. Second, as the nature of the cross-sectional study, we could not evaluate the longitudinal measurement error of arterial pressure within 3 to 5 mm Hg. Third, as the sample size was small and the 95% CIs are large. Still, the area under the ROC curve is large enough that ΔBP should be clinically useful. To overcome both of those limitations, a larger, prospective study would be helpful.

Fourth, data from some patients with shock were not included because there were no measurements of ScvO2. Those patients were less severely ill than the others, which could affect the results' generalizability. However, we believe that generalizability to patients who are not severely ill is not particularly important, as the primary utility of ScvO2, and thus of ΔBP, is in the management of patients such as the 111 severely ill patients whose data we did analyze.

6. Implications for future research and clinical practice

Although ScvO2 has been studied as a prognostic marker and a resuscitation goal in patients with shock [32,33], therapy targeting ScvO2 values of 70% or greater did not reduce all-cause mortality among sepsis patients in recent large randomized clinical trials [2–4]. However, Mirkor et al. [5] reported that ScvO2-assisted fluid therapy reduced postoperative complications, and several studies reported that ScvO2 could be a prognostic marker for surgical or trauma patients [5–8]. Therefore, ΔBP could be used as a prognostic marker or a goal for resuscitation among surgical or trauma patients. Furthermore, ScvO2 has also been studied as a surrogate marker of cardiac output [9,10]. Maintaining sufficient cardiac output is important when pure vasopressors are used [34]. ΔBP could be a surrogate marker of cardiac output when vasopressors or inotropic agents are used. Outcomes in patients with shock can be improved when advanced hemodynamic monitoring such as monitoring of cardiac output, stroke volume, stroke volume variation, and pulse pressure variation is used to guide therapy, but these indices are not monitored routinely, and arterial pressure monitoring remains the most commonly used tool, being applied in more than 80% of cases in Europe and in the United States [35]. One of the reasons may be that accurate measurement of cardiac output, stroke volume variation, and pulse pressure variation requires advanced and costly instrumentation. In contrast, ΔBP can be measured easily and relatively cheaply. Although further clinical studies of ΔBP are certainly needed, it could well become widely used in the management of critically ill patients.

7. Conclusions

The difference between invasively and noninvasively measured systolic blood pressure can indicate whether ScvO2 is lower than 70%. When that difference is greater than 0, ScvO2 is very likely to be lower than 70%.

Supplementary data to this article can be found online at http://dx.doi.org/10.1016/j.jcrc.2016.02.022.

Contributors

J. Kumasa conceived the study, collected the data, undertook primary analyses, and drafted the manuscript. A. Ohara conceived the study, undertook and supervised data analysis, and contributed to the manuscript. H. Kohata, K. Aoyagi, and S. Fukuma advised on data
analysis and presentation and contributed to the manuscript. S. Fukuhara supervised the study design, data analysis, interpretation of results, and refined the manuscript.

Acknowledgment

We thank the staff and patients of the Sakai City medical center for their support and participation in this study.

References