The Non-invasive Determination of Cardiac Output in Children: A Three-breath Technique

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In this study, the cardiac output of 11 children (5 days to 18 yr of age) was measured following cardiopulmonary bypass. Standard dye dilution cardiac outputs and an indirect Fick-CO₂ technique were simultaneously determined. A rebreathing maneuver is described to estimate the oxygenated mixed venous P CO₂ (PvCO₂). This estimate of PvCO₂ was combined with the end tidal P CO₂ and CO₂ production to give a non-invasive Fick estimate of the cardiac output. Non-invasive cardiac outputs correlated well with those measured by dye-dilution (r² = 0.94) over a range of cardiac outputs from 490–7280 ml/min. All non-invasive determinations were within 15% of the line of identity, and within 22% of averaged replicate dye-dilution values. Our results agree with previous comparisons of indirect Fick-CO₂ methods with invasive determinations of cardiac output. These data suggest that the indirect Fick-CO₂ technique offers a rapid, non-invasive alternative to invasive monitoring of cardiac output. (Key words: Anesthesia, pediatrics. Measurement technique, cardiac output: non-invasive.)

In 1956, Collier1 described a rebreathing technique to estimate the mixed venous P CO₂. Collier's "oxygenated" PVCO₂ is defined as the mixed venous P CO₂ measured in the presence of oxygen saturated hemoglobin. With Collier's technique, a patient rebreathes a gas mixture with a CO₂ partial pressure greater than the estimated PVCO₂ to obtain an equilibrium PVCO₂ estimate. Defares2 subsequently reported PVCO₂ estimates based on the asymptotic rise in P CO₂ during rebreathing. Refinements of the equilibrium and exponential techniques have been used to determine cardiac output by the indirect Fick-CO₂ method.3–7

Our initial attempts to reproduce stable estimates of PVCO₂ by the equilibrium method were unsuccessful in small (≤5.3 kg) subjects. Equilibration of CO₂ could not be obtained within three breaths, inspired and expired gas varied by more than 1 mmHg, and a plateau could not be sustained for 10 s.8 On the other hand, these criteria for an adequate equilibrium capnogram were easily replicated in larger subjects.

In this paper, we present a technique to estimate the oxygenated mixed venous P CO₂ (PETCO₂) in both large and small subjects. To reproducibly determine the PvCO₂ in both large and small subjects, we combined a controlled-rebreathing technique described by Fisher,9 with an equilibrium rebreathing approach. Our modification allows the inspired P CO₂ to equilibrate toward the expired P CO₂ during rebreathing. In contrast, Fisher's technique rigidly controls the inspired P CO₂. We calculated cardiac output combining the indirect Fick-CO₂ technique with this estimate of PVCO₂, the end-tidal P CO₂ (PETCO₂), and CO₂ production (vCO₂). These indirect Fick-CO₂ cardiac outputs were compared with simultaneous dye-dilution determinations.

Materials and Methods

The study was approved by the hospital Human Subject Review Committee. We studied 11 patients weighing 2.8–43 kg, aged 5 days–18 yr following elective surgical repair of congenital heart disease. One patient with a residual postoperative left-to-right intracardiac shunt was excluded. All cardiac outputs were measured 1–2 h after patients were transferred to the intensive care unit.

All patients were ventilated by a Siemens 900-C ventilator. We measured vCO₂ continuously with a Siemens model 930 CO₂ analyzer. This CO₂ analyzer determines vCO₂ by integrating the product of the instantaneous expiratory flow and the instantaneous expired P CO₂. VCO₂ was recorded when the vCO₂ measurement was stable for at least 30 s immediately before the cardiac output determination. Inspiratory and expiratory volumes were compared by a pitot tube flowmeter10 to assure no endotracheal tube leaks.

A Puritan-Bennett CO₂ analyzer (response time of 200 msec at 150 ml/min flow rate) equipped with a graph recorder was calibrated with dry 5.17% CO₂ before each study. PETCO₂ and all rebreathing CO₂ measurements were sampled from a 19-gauge catheter positioned near the distal tip of the endotracheal tube.

Pulmonary blood flow (PBF) was determined from the Fick equation:

\[
PBF(\text{ml/min}) = \frac{\dot{v}CO₂(\text{mlCO}_2/\text{min})}{CVCO₂ - CaCO₂(\text{mlCO}_2/\text{ml})},
\]

where \(\dot{v}CO₂\) = production of CO₂, \(CVCO₂\) = CO₂ content of mixed venous blood, and \(CaCO₂\) = CO₂ content of arterial blood. Distal PETCO₂ measurements were used to estimate arterial P CO₂ (PaCO₂).11 If arterial

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blood gases were not available, a Nellcor® pulse oximeter was used to measure O₂ saturation.

To measure PvCO₂, a closed 2-liter reservoir bag was filled from an anesthesia machine equipped with Quantiflex® CO₂ and O₂ flowmeters. The P CO₂ of the delivered mixture (P CO₂) was analyzed immediately before the rebreathing maneuver. The endotracheal tube of each patient was disconnected from the ventilator and the patients were allowed to rebreathe for at least four breaths a test gas of 6-9% CO₂ in oxygen. During rebreathing, the ventilator frequency and volume was manually approximated. The expired P CO₂ (P EXCO₂) following the second, third, and fourth breaths was recorded (fig. 1). This rebreathing maneuver was repeated two to five times with different concentrations of test gas, allowing at least 1 min before repetition. When PEXCO₂ - P CO₂ was plotted as a function of P CO₂, a least-squares linear regression was obtained (fig. 2). The x-intercept (P EXCO₂ = P CO₂) was used as an estimate of P CO₂. This modification of Fisher’s technique allows the P CO₂ to equilibrate toward P CO₂ during the rebreathing trial.

CO₂ contents were calculated from McHardy’s¹² mathematical derivation of the CO₂ dissociation curve. Corrections were applied for O₂ saturation and hemoglobin concentration.

\[
\text{CvCO}_2 - \text{CaCO}_2 = 11.02(\text{PvCO}_2^{0.306} - \text{PaCO}_2^{0.306}) - 0.015(\text{PvCO}_2 - \text{PaCO}_2)(15 - \text{Hb}) - 0.064(95 - \text{SaO}_2),
\]

where CvCO₂ - CaCO₂ is the mixed venous-arterial CO₂ content difference in ml of CO₂/100 ml of blood, PvCO₂ is the oxygenated mixed venous tension of CO₂ in mmHg, PaCO₂ is approximated by PetCO₂, SaO₂ is the percent O₂ saturation of arterial blood, and Hb is the hemoglobin concentration in gm/100 ml blood.

Dye dilution cardiac outputs were determined immediately after the indirect-Fick cardiac outputs. Cardiogreen dye (1.25–5.0 mg) was rapidly injected into a superior vena caval catheter or left atrial catheter at end-exhalation. A Waters COR-10 cardiac output computer continuously analyzed arterial blood and integrated the resultant dye-dilution curves. Indirect Fick-PvCO₂ cardiac outputs and dye-dilution outputs were compared by linear regression analysis.

In a parallel study, the oxygenated PvCO₂ was determined in 12 subjects (2.8–84 kg) using both the equilibrium technique⁸ and our three-breath method.

**Results**

Table 1 shows the demographic profile of our patients, including indirect-Fick and dye-dilution cardiac output determinations. The two-, three-, and four-breath cardiac outputs were calculated from the P CO₂-PETCO₂ gradient as described using PEXCO₂ after the second, third, and fourth breath.

The correlation between two-, three-, and four-breath Fick cardiac outputs and dye-dilution cardiac outputs was best using the three-breath maneuver (r² = 0.87, 0.94, and 0.90, respectively). Figure 3 shows the concordance plot of three-breath Fick-CO₂ cardiac outputs with simultaneous dye-dilution determinations. All Fick outputs were within 22% of the averaged dye-dilution values.

We found the three-breath technique gave estimates of PvCO₂ 2–4 mmHg lower than the equilibrium method. Figure 4 shows the correlation between the three-breath PvCO₂ determination and the equilibrium values (r² = 0.91) in 12 subjects. The difference between the two estimates of PvCO₂ did not vary with weight (r² = 0.29). Seven patients in the cardiac output study had rebreathing capnograms with a plateau allowing equilibrium estimates of PvCO₂. The mean equilibrium—three-breath PvCO₂ difference was 3.93 ± 1.51 mmHg (±SD) in this group.
**TABLE 1. Demographic and Cardiac Output Data**

<table>
<thead>
<tr>
<th>Patient</th>
<th>Weight (kg)</th>
<th>Age</th>
<th>Lesion</th>
<th>(\text{vCO}_2) (ml/min)</th>
<th>(\text{vCO}_2) (ml/kg/min)</th>
<th>(\text{Hb}) (g/dl)</th>
<th>Oxygen Saturation (%)</th>
<th>Number of Re-breathing Replicates</th>
<th>Calculated Cardiac Output (ml/min)</th>
<th>Mean Dye-Dilution Cardiac Output (ml/min)</th>
<th>(n = 3)</th>
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<tr>
<td>A</td>
<td>7.17</td>
<td>8 months</td>
<td>VSD</td>
<td>58</td>
<td>8.2</td>
<td>152</td>
<td>100</td>
<td>3</td>
<td>1130</td>
<td>2400</td>
<td>1270</td>
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<tr>
<td>B (Day 1)</td>
<td>12.6</td>
<td>3.5 yr</td>
<td>Tetralogy of Fallot</td>
<td>86</td>
<td>6.8</td>
<td>115</td>
<td>98.8</td>
<td>2</td>
<td>3490</td>
<td>2540</td>
<td>2030</td>
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<tr>
<td>B (Day 2)</td>
<td>12.1</td>
<td>3.5 yr</td>
<td>Tetralogy of Fallot</td>
<td>96</td>
<td>7.6</td>
<td>103</td>
<td>100</td>
<td>3</td>
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<td>2000</td>
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<td>C</td>
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<td>Aortic aneurysm</td>
<td>190</td>
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<td>110</td>
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<td>5020</td>
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<tr>
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**Discussion**

We describe a rapid, practical method to non-invasively determine cardiac output of small subjects. Previously described non-invasive Fick techniques rely on one of two methods to estimate \(\text{PvCO}_2\): 1) the equilibrium method of Collier as refined by McEnvoy et al., and 2) exponential methods. In infants, rapid \(\text{CO}_2\) recirculation yields a rebreathing capnograph that does not rise to an asymptotic value of \(\text{PvCO}_2\); despite altering rebreathing bag volumes, a continuous rising \(\text{P} \text{CO}_2\) with persistent ventilatory oscillations is seen.

To estimate cardiac output using the three-breath determination of \(\text{PvCO}_2\) described, arterial blood samples are not required. Although the blood-gas equilibrium of alveolar \(\text{CO}_2\) is a contentious issue, at rest the normal \(\text{PETCO}_2 - \text{PaCO}_2\) gradient has been measured to be \(-2.5\) mmHg. We found a similar gradient (\(-2\) to \(-4\) mmHg) between the three-breath estimate of \(\text{PvCO}_2\) and the equilibrium estimate in our study. The Fick cardiac outputs based on the equilibrium \(\text{PvCO}_2 - \text{PaCO}_2\) gradient should, therefore, be expected to be similar to those based on a three-breath \(\text{PbCO}_2 - \text{PETCO}_2\) gradient.

As pulmonary dead space increases, the Collier estimate of \(\text{PvCO}_2\) is not affected, since alveolar, end-tidal, and dead space gas should be in equilibrium. If dead space is increased, a large PETCO2-Paco2 gradient and, therefore, an artifically low cardiac output will result if the PVCO2-PETCO2 gradient is calculated using the

**Fig. 3.** A concordance plot showing the correlation between non-invasive Fick and dye-dilution determinations of cardiac outputs \((r^2 = 0.94)\). The line of identity is shown.

**Fig. 4.** Least squares regression plot of \(\text{Pco}_2\) as determined by the equilibrium and three-breath technique \((r^2 = 0.91)\). The regression line is represented by the curve \(y = 0.886x + 8.099\).
equilibrium method. The concordance of our Fick-CO₂ and dye dilution cardiac outputs indicates that the three-breath PRBCO₂-PETCO₂ gradient accurately reflects the PRBCO₂-Paco₂ gradient. We speculate that the same factors that lead to an increased PETCO₂-Paco₂ gradient also increase the three-breath PRBCO₂-PvCO₂ gradient, and yield accurate pulmonary blood flow determinations.

If this assertion is correct, we would expect that the three-breath technique will estimate the effective pulmonary blood flow (which will ordinarily equal the systemic cardiac output), will be resistant to error resulting from increased dead space (for example, rapid shallow respirations), and will underestimate the actual pulmonary blood flow in states with increased venous admixture (pulmonary hypotension or pulmonary embolism). Our finding that PBF can be rapidly, non-invasively estimated within 22% of dye-dilution methods suggests that this technique will be clinically useful.

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References