Pulse Oximetry during One-lung Ventilation

JAY B. BRODSKY, M.D.,* MARK S. SHULMAN, M.D.,† MARGARET SWAN, R.N.,‡ JAMES B. D. MARK, M.D.§

The variable intrapulmonary shunt that occurs during
selective one-lung ventilation (OLV) may result in hypoxemia, even when inspired oxygen concentration is
100%. An accurate method of continuously monitoring
oxygenation would increase the safety of OLV. We
therefore compared directly measured arterial hemo-
globin–oxygen saturation (\(S_aO_2\)) with \(S_aO_2\) obtained by
continuous noninvasive pulse oximetry to determine if
oximetry is useful during OLV.

METHODS

With the approval of our hospital Human Subjects
Committee, 19 adult patients scheduled for surgical
procedures in which we planned to use OLV consented
to be studied. Operations included 10 pulmonary lobec-
tomies, four pneumonectomies, two bilateral pulmonary
wedge resections, two thoracoscopies, and one esopha-
gastrectomy.

In the operating room, a cannula was inserted into a
radial artery for blood sampling and the sensor of a
pulse oximeter (N-100, Nellcor®, Hayward, California)
was placed on an index finger. Anesthesia was induced
with thiopental and succinylcholine given to facilitate
tracheal intubation with a double-lumen endobronchial
tube. General anesthesia was maintained with iso-flurane
(1.0–2.0%) and \(O_2\) (100%), supplemented with fentanyl,
iv, as needed. Ventilation was controlled with a tidal
volume of 12 ml/kg at a rate of 8–10/min. Seventeen
patients were placed in the lateral position following
anesthetic induction. Correct placement of the double-
lumen tube was verified by auscultation immediately
following tracheal intubation and again if the patient
was transferred from the supine to lateral position.
The inspired oxygen concentration was maintained
at 100% throughout the case. During surgery, the
exposed lung was collapsed in order to improve surgical
exposure. Ventilator settings were left unchanged during
OLV. Arterial blood was sampled and \(S_aO_2\) analyzed by
CO-Oximeter® (IL 282, Instrument Laboratories, Menlo
Park, California) immediately prior to the start and then
every 5 min during OLV. These \(S_aO_2\) values were
compared with the \(S_aO_2\) reading on the digital display
of the pulse oximeter at the time the arterial samples
were obtained.

RESULTS

A total of 120 matched measurements were made for
the 19 patients studied. The average time of OLV was
50 min (range 10–95 min). During OLV, \(S_aO_2\) ranged
between 79–100%. Figure 1 shows the per cent error
of the estimate of \(S_aO_2\) for the 120 matched samples
comparing noninvasive pulse oximetry with direct arterial
blood analysis.

Data from the five patients who had at least one
\(S_aO_2\) measurement <90% are shown in figure 2. The
35 pooled data points from these patients were analyzed
by analysis of linear regression. Correlation coefficient
(R) was 0.93. In each case, hypoxemia was initially
detected by pulse oximetry and later confirmed by the
CO-Oximeter.®

Four patients were hypotensive (mean arterial pressure
[MAP] <60 mmHg [range 47–120 mmHg]) during
OLV. The matched \(S_aO_2\) determinations were in very
close agreement (<2.0% difference) during periods of
hypotension.

Following reinflation of the collapsed lung, \(S_aO_2\) re-
turned to pre-OLV levels. The tracheas of all patients
were extubated at the completion of surgery.

DISCUSSION

The hypoxemia that can occur during OLV makes
rapid, accurate assessment of oxygenation extremely
important. Direct arterial blood gas analysis for \(S_aO_2\) is
reliable, but the method is invasive and the intermittently
obtained information is not immediately available. Fre-
quent blood gas measurements are expensive.

Monitoring transcutaneous oxygen tension (PtCO₂) has
been recommended for OLV. PtCO₂ monitors are
noninvasive and provide continuous information. How-
ever, PtCO₂ sensors need 10 min to warm-up before they
can be used, and the skin beneath the sensor must be

* Associate Professor (Anesthesiology).
† Assistant Professor (Anesthesiology).
‡ Research Assistant (Anesthesiology).
§ Professor (Surgery), Head—Division of Thoracic Surgery.

Received from the Department of Anesthesia and Surgery, Stan-
ford University School of Medicine, Stanford, California 94305.
Accepted for publication March 18, 1985. Presented in part at the
1984 Annual Meeting of the American Society of Anesthesiologists,
New Orleans, Louisiana.

Address reprint requests to Dr. Brodsky.

Key words: Anesthesia; thoracic; one-lung ventilation. Equipment:
pulse oximetry. Monitoring: oxygen.
heated to 44–45° C with a potentially harmful local heat source in order to "arterialize" the blood. Normally, \( P_{\text{tcCO}_2} \) is approximately 80% of actual arterial oxygen tension (\( P_{\text{aO}_2} \)). \( P_{\text{tcO}_2} \) is accurate only while the patient is hemodynamically stable with a cardiac index greater than 2.21 \( \text{min}^{-1} \cdot \text{m}^2 \). During periods of hypotension, \( P_{\text{tcO}_2} \) does not accurately follow \( P_{\text{aO}_2} \) but drops because of decreased cardiac output and inadequate tissue oxygen delivery. Therefore, a low \( P_{\text{tcO}_2} \) reading may be misleading if \( P_{\text{aO}_2} \) is adequate but tissue perfusion is not. Even for normotensive patients, \( P_{\text{tcO}_2} \) determinations may be inaccurate. The simultaneously obtained readings from two identical \( P_{\text{tcO}_2} \) sensors placed next to each other on the skin of 21 surgical patients were compared. There was an enormous variability between these matched \( P_{\text{tcO}_2} \) measurements, prompting the investigators to question the reliability of \( P_{\text{tcO}_2} \) monitoring in estimating the value of, or changes in, \( P_{\text{aO}_2} \) during surgery.

Like the \( P_{\text{tcO}_2} \) monitor, the pulse oximeter is noninvasive and gives continuous information. However, pulse oximetry requires no heat source and is ready to use immediately. The pulse oximeter works by placing a

FIG. 1. The range of differences between arterial hemoglobin--oxygen saturation (\( S_{\text{aO}_2} \)) obtained by CO-Oximeter* and pulse oximeter are shown.

FIG. 2. The pooled data from five patients with \( S_{\text{aO}_2} \) < 90% during one-lung ventilation are shown. The pulse oximeter accurately measured \( S_{\text{aO}_2} \) during periods of hypoxemia.

FIG. 3. The changes in \( S_{\text{aO}_2} \) during one-lung ventilation in a 55-year-old man undergoing left upper lobectomy for carcinoma are shown. Early recognition of hypoxemia by pulse oximetry allowed us to treat the patient immediately with PEEP to the ventilated right lung. When no improvement was evident, incremental amounts of CPAP were added to the nonventilated left lung until \( S_{\text{aO}_2} \) returned to a satisfactory level.
pulsating arterial vascular bed between a light source and a detector. The optical transducer used in the Nellcor® instrument consists of two light-emitting diodes and a photocell mounted in adhesive tape. The pulsating vascular bed, by expanding and contracting, creates a change in the light path that modifies the amount of light detected. Nonpulsatile substances such as skin, bone, and venous blood are not detected. In order to determine the percentage of arterial hemoglobin saturated with oxygen, the oximeter measures the ratio of the pulse amplitude of a pulse of red light (660 nm) and compares it with the pulse amplitude of the same pulse in infrared light (940 nm). The ratio varies, depending upon the relative fraction of saturated to unsaturated hemoglobin in the arterial blood. This ratio is used to calculate the $\text{SaO}_2$.

Pulse oximetry is accurate for a wide range of hemodynamic conditions as long as a pulse is present beneath the sensor. The oximeter we used accurately measures $\text{SaO}_2$ to 70%. Early recognition of hypoxemia ($\text{SaO}_2 < 90\%$) by oximetry enabled us to institute steps to improve oxygenation, as illustrated in figure 3. Oxygenation can be optimized during OLV by a variety of means including CPAP to the nonventilated lung, PEEP to the ventilated lung, or discontinuation of OLV.

We found no clinically significant differences between directly and transcutaneously measured $\text{SaO}_2$. With the pulse oximeter the information was available sooner, hence, there was no delay waiting for the results of blood gas analysis before beginning appropriate therapy. Although we still place an indwelling arterial line for blood pressure and arterial blood gas monitoring during thoracic operations, we now also monitor all our patients by pulse oximetry. We no longer are dependent on frequent arterial blood gas samples to follow arterial oxygenation during OLV.

REFERENCES


Anesthesiology
63:214–216, 1985

Epidural Block Using Large Volumes of Local Anesthetic Solution for Intercostal Nerve Block

ROBERT E. MIDDAGH, M.D.,* EMIL J. MENK, M.D.,† WILLIAM J. REYNOLDS, M.D., PH.D.,‡ JOHN M. BAUMAN, M.D.,§ MICHAEL A. CAWTHON, D.O.,¶ MICHAEL F. HARTSHORNE, M.D.**

Repeated intercostal nerve blocks for analgesia have been used in postoperative patients, e.g., cholecystectomy. Adequate analgesia improves pulmonary compliance with coughing and deep breathing, thereby decreasing the risk of pulmonary atelectasis and ventilation/perfusion abnormalities.

Continuous intercostal nerve blockade over five dermatomes has been achieved by inserting a catheter in one intercostal space. Murphy has used this technique successfully in patients with rib fractures and following cholecystectomy. How can a single injection of anesthetic into one intercostal space produce analgesia over several dermatomes? In cadaver studies, Nunn and Slavin identified the spread of an agent using small volumes of dye solutions. The use of radionuclides provides a method wherein the spread of anesthetic


---

* Director Surgical Intensive Care Unit, Anesthesia and Operative Service.
† Resident, Anesthesia and Operative Service.
‡ Chief, Anesthesia and Operative Service.
§ Fellow, Nuclear Medicine Service, Department of Radiology.
¶ Assistant Chief, Nuclear Medicine Service, Department of Radiology.
** Chief, Nuclear Medicine Service, Department of Radiology.

Received from the Anesthesia and Operative Service and the Nuclear Medicine Service, Department of Radiology, Brooke Army Medical Center, Fort Sam Houston, Texas. Accepted for publication March 18, 1985.

The opinions or assertions contained herein are the private views of the authors and are not to be construed as reflecting the views of the Department of the Army or the Department of Defense.

Address reprint requests to Dr. Middagh: 510 West Oak, University City, Texas 78148.

Key words: Anesthetic techniques: regional; intercostal.