

❖ Purpose:

- Outline guidelines for monitoring oxygen saturation (SpO<sub>2</sub>), end tidal capnography (ETCO<sub>2</sub>), and carbon monoxide (SpCO). Monitoring these gases will allow responders to better evaluate patients in the field, and will also help to diagnose specific problems relative to oxygenation, ventilation, and metabolism.
- Monitoring SpO<sub>2</sub> is considered both a BLS and ALS provider skill; while monitoring ETCO<sub>2</sub> is reserved for ALS providers.

❖ Monitoring SpO<sub>2</sub>

➤ Overview/Background

- SpO<sub>2</sub> measures the percentage of hemoglobin in a patient’s red blood cells that have fixed oxygen. Thus, this tool is a rough measurement of a patient’s oxygenation. This differs from PO<sub>2</sub>, which is a measure of the actual amount of oxygen dissolved in blood plasma. PO<sub>2</sub> and SpO<sub>2</sub> normally are very closely aligned, though SPO<sub>2</sub> readings will lag behind falling PO<sub>2</sub> numbers as a patient becomes hypoxic.
- Factors that decrease SpO<sub>2</sub> include decreased pH (acidosis), increased blood levels of CO<sub>2</sub>, and increased physiologic temperature. Factors that increase SpO<sub>2</sub> include increased pH (alkalosis), decreased blood levels of CO<sub>2</sub>, and decreased physiologic temperature.
- Because SpO<sub>2</sub> measures the ratio of saturated to unsaturated hemoglobin in arterioles, its accuracy can be impaired by any factor that influences arteriolar blood flow. Conditions that may cause false low readings include a cold environment, hypotension, and vasoconstriction from smoking or vascular disease. Substantial motion, fingernail polish, bright light, and shivering can also falsely lower readings. Carbon monoxide fixed to hemoglobin can cause falsely elevated readings, though this can be mitigated when a multi-gas sensing system is employed.

➤ Monitoring Indications

- All patients in respiratory distress.
- Patients with altered mentation, or in any circumstance where airway or ventilation is impaired or may become impaired.
- Use as a “5th vital sign” to monitor the overall status of a patient in significant physiologic distress.
- May be used to detect blood flow to extremities with compromised blood flow/major injuries by placing the oximeter probe onto tissue distal to a fracture or crush injury.

SpO <sub>2</sub> Measurements, Interpretation, and Interventions		
SpO <sub>2</sub> Reading (%)	Interpretation	Intervention
95-100%	Normal	Maintain saturation
91-94%	Mild Hypoxemia	Increase O <sub>2</sub> delivery to increase saturation
86-90%	Moderate Hypoxemia	Increase O <sub>2</sub> to increase saturation. Assess and possibly increase ventilations
< 85%	Severe Hypoxemia	Increase O <sub>2</sub> to increase saturation. Increase ventilations

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❖ Monitoring ETCO<sub>2</sub>

➤ Overview/Background

- End-tidal CO<sub>2</sub> (ETCO<sub>2</sub>) measures of exhaled CO<sub>2</sub> at the end of respiration. It provides excellent real-time information about the effectiveness of a patient's ventilation. ETCO<sub>2</sub> can be used to estimate PaCO<sub>2</sub> (the partial pressure of carbon dioxide in blood plasma) in patients with normal lungs. Normal PaCO<sub>2</sub> and ETCO<sub>2</sub> values range from 35-45 mmHg.
- ETCO<sub>2</sub> is very effective at identifying hypo- and hyperventilating patients, as well as those patients who develop sudden apnea. ETCO<sub>2</sub> monitoring can help to detect problems with advanced airway adjuncts and positive pressure ventilation. Analysis of a patient's capnographic wave form and trending of this wave form can help responders to identify bronchospasm, increased respiratory depression, inadvertent esophageal intubation, and a host of other issues.
- While capnography is a direct measurement of ventilation in the lungs, it also indirectly measures metabolism and circulation. For example, an increased metabolism will increase the production of carbon dioxide, increasing the ETCO<sub>2</sub>. A decrease in cardiac output will lower the delivery of carbon dioxide to the lungs, decreasing the ETCO<sub>2</sub>.

❖ Monitoring Indications

➤ Mandatory:

- Respiratory arrest or respiratory distress requiring positive pressure ventilation via BVM, King Tube, or ETI.
- Cardiac arrest

➤ Recommended:

- Hypoventilation/respiratory insufficiency.
- Respiratory distress of any etiology
- Chest pain with respiratory distress
- Congestive heart failure
- Altered mentation/Overdose
- Patients who have received medications which may alter respirations (narcotics, benzodiazepines)

➤ Note: Colorimetric CO<sub>2</sub> monitoring may be used in those instances that preclude the use of waveform capnography.

➤ ETCO<sub>2</sub> Measurements, and Interventions Interpretation.

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SPONTANEOUS RESPIRATION ONLY		
ETCO <sub>2</sub> Reading	Interpretation	Intervention
35-45 mmHg	Normal ETCO <sub>2</sub>	Maintain ventilation
> 45 mmHg	Hypoventilation	Increase ventilation
< 35 mmHg	Hyperventilation	Decrease ventilation

➤ ETCO<sub>2</sub> In Cardiac Arrest

- Monitoring ETCO<sub>2</sub> during cardiac arrest measures cardiac output, and is a good way to measure the effectiveness of CPR. Reductions in ETCO<sub>2</sub> during CPR are associated with comparable reductions in cardiac output. Note: Patients with extended down times may have ETCO<sub>2</sub> readings so low that the quality of compressions will show little difference in this number.
- ETCO<sub>2</sub> may be the first sign of return of spontaneous circulation (ROSC). During cardiac arrest, if the CO<sub>2</sub> number increases rapidly, stop CPR and check for pulses. Conversely, rapid drops in ETCO<sub>2</sub> in a patient with ROSC may indicate that pulses have been lost and that CPR needs to be resumed.
- An ETCO<sub>2</sub> level of 10 mmHg or less, measured 20 contiguous minutes after the initiation of advanced cardiac life support accurately predicts death in patients with cardiac arrest associated with electrical activity but no pulse. In patients for whom this is the case, resuscitation may be discontinued per County Guidelines.
- ROSC patients will usually present with an ETCO<sub>2</sub> of 18 or greater and will usually quickly climb to above 30 mm Hg in cases that will ultimately survive to discharge.

➤ ETCO<sub>2</sub> in Bronchospasm/Asthma

- Bronchospasm will produce a characteristic “shark fin” capnographic wave form, as the patient has to struggle to exhale, creating a sloping “B-C” upstroke. The shape is caused by uneven alveolar emptying.
- Asthma values change with severity. With mild asthma, the CO<sub>2</sub> will drop (below 35 mm Hg) as the patient hyperventilates to compensate. As the asthma worsens, the CO<sub>2</sub> levels will rise to normal. When the asthma becomes severe, and the patient is tiring and has little air movement, the CO<sub>2</sub> numbers will rise to dangerous levels (above 60 mmHg).

❖ Monitoring SpCO

➤ Overview/Background

- Carbon monoxide (CO) is an odorless, colorless, tasteless heavier-than-air gas that is the most common product of combustion. Its affinity for hemoglobin is 250 times greater than that of oxygen, and when enough carbon monoxide is fixed to hemoglobin, hypoxia can occur. High carbon monoxide levels can cause fatal anoxia.

➤ Monitoring Indications

- SpCO monitoring should be included in the medical monitoring conducted at Emergency Worker Rehab.

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**SpCO Measurements and Interpretation**

SpCO Level	Interpretation	Signs and Symptoms
< 3%	Normal Levels (nonsmokers)	None
4% - 11%	Minimal Levels	Usually none; possibly mild headache nausea
12% - 20%	Mild exposure	Headache, n/v, dizziness, blurred vision
21% - 40%	Moderate exposure	Confusion, syncope, chest pain, weakness, rapid HR
41% - 59%	Severe exposure	Dysrhythmias, hypotension, MI, respiratory arrest Seizures, coma, pulmonary edema, cardiac arrest
>60%	Fatal	Death 100% of the time

- Cherry red skin color is not always present in carbon monoxide poisoning, and when present, is often a late finding.
  - Smokers often will have a chronic SpCO level of 4-10%
  - Most non-smokers have a SpCO level less than 2.5%
  - County Emergency Worker Rehab Plan endorsed by County Fire Chiefs, sets green (return to duty) level at <6; yellow level (hold and recheck at 20-minute mark) at 6-12%; and red level (must be evaluated by MD) at >12%.
  - Fetal hemoglobin has a much greater affinity for SpCO than adult hemoglobin. Pregnant mothers may exhibit mild to moderate symptoms, yet the fetus may have devastating outcomes.
  - Remember, SpCO poisoning is the great imitator. It can “masquerade” as many other etiologies. When in doubt, check for it.
  - Missed SpCO exposure often leads to death and disability.
  - CO poisoning is a particular risk for firefighters.
- SpCO Treatment
- Treatment is based on the severity of symptoms.
  - Treatment generally indicated with SpCO > 12-15%, but may begin at any level in which the patient is experiencing symptoms.
  - High-concentration O2 should be administered to displace CO from hemoglobin.
  - Be prepared to treat complications (e.g., seizures, cardiac ischemia).
  - Patients with severe poisoning may benefit from hyperbaric chamber therapy. The receiving ED will arrange this.

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