Arterialised earlobe blood gas analysis: an underused technique

A D Pitkin, C M Roberts, J A Wedzicha

Abstract

Background – Techniques for sampling arterialised capillary blood from the finger pulp and the earlobe were first described over two decades ago but, although close agreement between arterial values and earlobe samples has been demonstrated in normal subjects, this technique is not in common usage.

Methods – Forty patients with chronic lung disease and a wide range of arterial blood gas values were studied. Simultaneous earlobe and arterial samples were drawn with the patient at rest and analysed in the same blood gas analyser. The respiratory function laboratory staff in 50 UK hospitals with a respiratory department were telephoned and asked whether the technique was used in their hospital and the reasons, if known, for not adopting it.

Results – Earlobe and arterial blood gas tensions agreed closely over a wide range of values of arterial pH, Pco2 (mean difference 0·21, 95% confidence intervals −0·24 to +0·67 kPa) and Po2 (mean difference −0·17, 95% confidence intervals −1·09 to +0·75 kPa), especially at arterial Po2 values lower than 8 kPa. Of 50 UK centres surveyed 18% used the arterialised earlobe technique and 4% had plans to introduce it. Reasons for not using it were lack of knowledge in 64%, no blood gas analyser in 6%, the technique was considered inaccurate in 4%, and insufficient staff in 4%.

Conclusions – Although earlobe blood gas analysis is sufficiently accurate to be reliably substituted for arterial sampling in routine clinical practice, most centres in the UK do not use the technique. The main reasons for this appear to be lack of knowledge of its existence and uncertainty about its accuracy.

Measurement of arterial blood gas tensions is a routine part of the assessment of patients with acute and chronic respiratory disorders producing abnormalities of gas exchange. Blood sampling by direct arterial puncture is the accepted technique established in clinical practice. This method, however, requires qualified medical staff to perform it and may result in significant discomfort and morbidity for the patient. Alternative methods such as cutaneous pulse oximetry have also been used to estimate arterial oxygen tension but corre-
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Comparative data for pH, Po2, and Pco2 values of simultaneous arterial and capillary blood samples in 40 patients

<table>
<thead>
<tr>
<th></th>
<th>Range</th>
<th>Maximum difference</th>
<th>Mean difference</th>
<th>95% limits of agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>pH</td>
<td>7.32—7.50</td>
<td>0.034</td>
<td>+0.007</td>
<td>−0.008 to +0.022</td>
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<tr>
<td>Pco2 (kPa)</td>
<td>3.87—10.03</td>
<td>0.78</td>
<td>+0.21</td>
<td>−0.24 to +0.67</td>
</tr>
<tr>
<td>Po2 (kPa)</td>
<td>4.42—12.97</td>
<td>1.6</td>
<td>−0.17</td>
<td>−1.09 to +0.75</td>
</tr>
</tbody>
</table>

Results

The range, mean, standard deviation, and 95% limits of agreement for pH and blood gas values obtained by simultaneous sampling of earlobe capillary and arterial blood in 40 patients are shown in the table. The concordance between arterial and earlobe blood gas tensions was good throughout a wide range of values of arterial Po2 (fig 1) and Pco2 (fig 2). A particularly good correlation between samples was observed at arterial Po2 values lower than 8 kPa. Above this level earlobe Po2 values tended to be slightly lower than arterial Po2 values. Nearly all values, however, lie within 0.5 kPa or less and underestimation of true arterial Po2 at higher levels of oxygenation is unlikely to be of clinical significance. The correlation between Pco2 measurements derived from the two methods is even better with the earlobe technique, tending towards slightly higher values. The mean difference between samples was, however, only 0.21 kPa.

Fifty hospitals were surveyed by telephone. Of these, nine (18%) used the arterialised earlobe technique and two (4%) had plans to introduce it. In 32 (64%) of the 52 remaining hospitals the main reason for not using earlobe blood gases was that the laboratory staff were unaware of the technique. In three hospitals (6%) a blood gas analyser was not available in the laboratory. In two centres (4%) the technique was thought to be inaccurate, and in a further two (4%) there were insufficient technical staff to carry out the procedure.

Discussion

The close agreement between arterial and earlobe blood gas values found in our study confirms the findings of earlier work in normal subjects where earlobe blood gas values have been found to be sufficiently accurate for use in exercise testing to calculate cardiac output, venous admixture, and dead space. Our findings indicate that this accuracy extends throughout the much wider ranges of arterial Po2 and Pco2 found in patients with respiratory disease, and suggest that earlobe blood gas analysis can reliably be extended from a research technique into routine clinical practice.

Earlobe blood gas measurement could have a valuable role in the assessment of patients for long term oxygen therapy in accordance with published guidelines. Although pulse oximetry is useful for screening, it is not sufficiently precise to be substituted for direct arterial Po2 measurement. Earlobe blood gas analysis, however, is particularly accurate at arterial Po2 values less than 8 kPa, can determine arterial Pco2, and is painless enough to allow several samples to be taken on a single occasion with the patient breathing oxygen at varying flow rates to ensure adequate correc-
tion of their hypoxaemia. Thus, provision of this technique on an outpatient basis would facilitate appropriate prescription of long term oxygen therapy (LTOT) by general practitioners. Although this may necessitate additional technician time in the lung function laboratory, it would eliminate the need for qualified medical staff to perform arterial puncture. Additional savings might be made by reducing inappropriate prescription of LTOT. At this hospital over 3000 earlobe blood gas measurements are performed each year in inpatients and outpatients. Many of them spontaneously indicate their preference for earlobe sampling.

Collection of arterialized earlobe samples does not occur within a closed system and therefore the technique poses a theoretical risk of infection to the operator from exposure to the patient’s blood. The amount involved is small (about 1–2 ml), but appropriate measures to eliminate any possible hazard of infection should be used. In our unit the operator wears gloves and an absorbent disposable towel is placed underneath the earlobe. The tiny incision bleeds for a few seconds only and is then dressed with a small waterproof plaster. In contrast, arterial puncture exposes the operator to the risk of a needlestick injury and, furthermore, inoculation of blood is more likely with the low friction syringes often used for blood gas analysis. Spillage of the contents of the syringe may also occur during injection of the sample into some analysers; this is less likely to occur during aspiration of an earlobe sample from its glass capillary tube.

Our survey included most of the teaching hospitals and specialist centres for respiratory medicine within the UK, and this sample may be biased towards units more likely to employ the technique. The proportion of all UK hospitals using earlobe blood gas analysis is unlikely to be higher than the 18% found in our survey, which also suggests that the main reason for not using it is lack of knowledge of the technique’s existence or its accuracy. Other reasons identified in our survey for not using earlobe blood gas analysis, such as availability of staff and blood gas analysers, are logistical and unique to each centre. Concern that delayed analysis of the sample renders the result inaccurate applies more to conventional plastic syringes than to glass capillary tubes which have been shown to preserve blood gas tensions better than glass or plastic syringes at room temperature.

In summary, based on the results of this study we conclude that earlobe blood gas analysis is a valuable technique in the management of patients with all forms of respiratory disease producing abnormalities of gas exchange, and that only a minority of centres use it. The principal reasons for its underuse are a lack of awareness of its existence and concern over its accuracy, neither of which should preclude its adoption in many more hospitals in the UK.

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