ORIGINAL ARTICLE

Continuous end-tidal carbon dioxide monitoring for confirmation of endotracheal tube placement is neither widely available nor consistently applied by emergency physicians

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OBJECTIVES: To determine the availability of end-tidal CO2 measurement in confirmation of endotracheal tube placement in the non-arrest patient, and to assess its use in academic and non-academic emergency departments.

METHODS: Emergency physicians in the USA were surveyed by mail in the beginning of the year 2000 regarding availability at their institution of both colorimetric/quantitative and quantitative end-tidal CO2 capnography, frequency of use in their own practice, and descriptor of their hospital (academic, community teaching, and community non-teaching). Additionally, data were obtained from the National Emergency Airway Registry 97 series (NEAR) about how many intubations used this method of confirmation. NEAR site coordinators were surveyed as well.

RESULTS: Of 1000 surveys, 550 were returned (55%). Colorimetric technology existed in 77% of respondents’ hospitals (n = 421); 25% of respondents (n = 138) had continuous monitoring capability. Physicians practising at academic hospitals were more likely to have continuous monitoring (36%; n = 196) than community teaching institutions (32%; n = 173) and non-teaching centres (18%; n = 100) (p < 0.001). Among physicians who had this technology available, only 14% (n = 19) “always” used it in non-arrest intubations; 57% “rarely” or “never” employed it (n = 75). Among NEAR centres (institutions committed to monitoring current airway practices) only 12% of 6009 (n = 716) intubations used continuous end-tidal CO2 measurement. Of these practitioners, only 40% “always” used it (n = 6/15) [83% response rate (n = 29/35)].

CONCLUSIONS: Despite recommendations from national organisations that endorse continuous monitoring of end-tidal CO2 for confirming endotracheal tube placement, it is neither widely available nor consistently applied.

Endotracheal intubation is “a potential minefield for disaster”. Errors in its performance can be associated with high morbidity and mortality for the patient, and legal liability for the practitioner. Many methods exist for the verification of successful tube placement in the trachea, including watching the tube pass through the cords, pulse oximetry monitoring, and listening for breath sounds. However, none of these are theoretically as accurate as end-tidal carbon dioxide (CO2) monitoring in the non-cardiac-arrest patient. A recent UK survey of intensivists found that although 80% of intensive care units have end-tidal CO2 monitoring capability, only 50% of these use it to confirm correct tube placement. Of these 50%, only approximately a third use it for every intubation.1 Recently, the American College of Emergency Physicians (ACEP) joined several other institutions in recommending that this modality be used in confirmation and endorse it as the “most accurate”.1,2 However, two things remain unclear: (a) What the availability of this modality is in emergency departments and (b) whether physicians’ practice patterns reflect the strong wording of these positions?

The purpose of the present study was to understand more fully if this technology is actually being used in emergency departments.

METHODS: PART I
Survey design and population
A single-page survey was developed and validated on a pilot sample of 10 emergency physicians. The survey population consisted of 1000 active emergency physician members of the ACEP. A random sample of active physicians’ names and addresses were purchased from the organisation. The survey portions of the study (parts I and II) met the criteria for exemption from the institutional review board requirement for informed consent from participants.

Survey content and administration
A single mailing was carried out via US Mail. No incentives were offered for responding, though we provided a self-addressed stamped envelope for returning the completed survey. Participants were asked voluntarily for their help. Questions asked included whether the respondent’s primary hospital had colorimetric and/or quantitative end-tidal CO2 measurement available, how often the physician used each of these modalities in confirming non-arrest intubations (always, often, rarely, never), and the type of hospital (academic, community teaching, or community non-teaching) at which the respondent practised. A multiple-choice format was used, and the name of the respondent’s hospital was elicited, though in a separate area of the questionnaire. Respondents were notified that this information would be removed before data analysis. The author’s email address was provided. See box 1 for the complete survey instrument.

Data analysis
Percentages were calculated for answers to questions 1, 2, 4, 5, and 8. Multivariate analysis was performed regarding the relation between type of hospital (question 8) and answers to
Box 1: Survey instrument

1. Is colorimetric ETCO2 measurement (e.g. Easy-Cap) available at your department?
   - Yes
   - No

2. If so, how often do you use this method to confirm ETT placement in non-arrest intubations?
   - Always
   - Often
   - Rarely
   - Never

3. If you have this modality available but choose not to always use it, why not? (May choose more than one)
   - Feel other methods (e.g. direct visualization, auscultation of breath sounds) are more effective
   - Cost
   - Difficulty of use
   - Use continuous monitoring instead
   - Other

4. Is continuous, quantitative ETCO2 monitoring available in your department?
   - Yes
   - No

5. If so, how often do you use this method to confirm ETT placement in non-arrest intubations?
   - Always
   - Often
   - Rarely
   - Never

6. If you have this modality available but choose not to always use it, why not?
   - Feel other methods (e.g. direct visualization, auscultation of breath sounds) are more effective
   - Cost
   - Difficulty of set-up
   - Other

7. If you have both colorimetric AND continuous monitoring available, describe how you use these.
   - Only use colorimetric method
   - Only use continuous method
   - First confirm with color change, then hook up quantitative monitor
   - Nurse already has continuous monitor set up so colorimetric version unnecessary
   - Other
   - Not applicable

8. Please select the best descriptor of your hospital.
   - Academic
   - Community teaching hospital
   - Community non-teaching hospital

ETCO2, end-tidal carbon dioxide; ETT, endotracheal tube

Questions 1, 2, 4, and 5 (those assessing availability and use of modalities) were excluded from the data analysis due to lack of usable data.
In October 2001, the ACEP published the following recommendations:

During intubation, direct visualization of the endotracheal tube passing through the vocal cords into the trachea constitutes firm evidence of correct tube placement, but should be verified with additional techniques.

End-tidal CO₂ detection, either qualitative, quantitative, or continuous, is the most accurate and easily available method to monitor correct endotracheal tube position in patients who have adequate tissue perfusion.

The National Association of EMS Physicians (NAEMSP) echoes this sentiment in its position statement:

In the patient with a perfusing rhythm, end-tidal CO₂ detection is the best method for verification.

Expired CO₂ detectors are very reliable in patients with perfusing rhythms and are recommended to confirm tube position in these patients (Class IIa).

Finally, the Association of Anaesthetists of Great Britain and Ireland and the American Society for Anesthesiologists (ASA) embrace the use of end-tidal CO₂ detection in their guidelines:

[Capnography is] essential to the safe conduct of anaesthesia.

Continual monitoring for the presence of expired carbon dioxide shall be performed unless invalidated by the nature of the patient, procedure or equipment.

The present study found that even in the light of strong position statements supporting the use of end-tidal CO₂ monitoring in the confirmation of intubations by many professional societies in emergency medicine, anaesthesia, and prehospital care, emergency departments are not universally endorsing this modality. The vast majority of physicians did not have quantitative monitoring at their disposal at the time of the study. Though many more do have the use of qualitative methods such as colorimetric devices, even this number is not 100%. The type of hospital influences the likelihood of available technology. Even the NEAR sites, ostensibly centres committed to monitoring and researching airway practices, report similarly low rates of availability and use of this modality.

More disheartening is the fact that physicians have not embraced this practice even if it is available in their practice settings. Though not officially analysed in the study results because of a lack of valid responses, the survey instrument did include a space for respondents to write in reasons they might have felt such monitoring was not necessary. Reasons cited for this included the belief that other methods, such as colorimetric monitoring, pulse oximetry, visualising tube condensation, or chest radiography were just as reliable, and a perceived difficulty of set-up. Unfortunately, literature does not support the adequacy of alternative methods. In the presence of a continuous waveform, quantitative assessment of end-tidal CO₂ should be the gold standard for intubation confirmation. Pulse oximetry may remain in the normal range for up to five minutes after the cessation of lung ventilation. Colorimetric or qualitative assays have reported sensitivities of as low as 72% in one prospective study of 106 patients for detecting esophageal intubation. Another study found a sensitivity of 98% but a specificity of only 78%. A recent Best Evidence Topic Report in this journal concluded that:

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Esophageal detector devices have a reported accuracy of as low as 50%. Clearly, these alternative methods are not enough, though the study respondents may not be aware of these numbers.

Limitations:

This study does have limitations that open the way for future research in this area. The response rate of 55%, although good...
for a survey, does leave the practices of almost one half of the target population unknowable. Data from the study population of ACEP members may not be generalisable to emergency physicians as a whole, especially those in other countries. The nature of a survey study makes the possibility of reporting bias inevitable. Finally, capnography is a new, rapidly expanding technology that may be more available today than at the time of the study. Still, it would seem that those who responded to the survey would be over-representative of physicians who use this, suggesting that real life numbers would actually be even lower.

CONCLUSIONS
This study shows that despite strong calls for the practice of confirming endotracheal tube placement with end-tidal CO₂ measurement, our specialty’s practitioners are not in compliance. Physicians and operational managers in emergency departments need to be further educated so that this technology becomes more widely available and more consistently used.

Competing interests: none declared

REFERENCES
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