



Editor's choice
Scan to access more
free content

Department of Emergency
Medicine, Orlando Regional
Medical Center, Orlando,
Florida, USA

Correspondence to

Dr Christopher L Hunter,
Department of Emergency
Medicine, Orlando Regional
Medical Center, Orange County
EMS, 2002-A E. Michigan
Street, Orlando, FL 32806,
USA;
c_hunter77@hotmail.com

Received 12 November 2013

Revised 13 March 2014

Accepted 31 May 2014

Published Online First

1 July 2014

Prehospital end-tidal carbon dioxide differentiates between cardiac and obstructive causes of dyspnoea

Christopher L Hunter, Salvatore Silvestri, George Ralls, Linda Papa

ABSTRACT

Background Differentiating between cardiac and obstructive causes for dyspnoea is essential for proper management, but is difficult in the prehospital setting. **Objective** To assess if prehospital levels of end-tidal carbon dioxide (ETCO₂) differed in obstructive compared to cardiac causes of dyspnoea, and could suggest one diagnosis over the other.

Methods We conducted a retrospective cohort study among patients transported by emergency medical services during a 29-month period who were diagnosed with either obstructive pulmonary disease or congestive heart failure (CHF) by ICD-9 codes. Initial prehospital vital signs, including ETCO₂, were recorded. Records were linked by manual archiving of emergency medical services and hospital data.

Results There were 106 patients with a diagnosis of obstructive or cardiac causes of dyspnoea that had prehospital ETCO₂ levels measured during the study period. ETCO₂ was significantly lower in patients diagnosed with CHF (31 mm Hg 95% CI 27 to 35) versus obstructive pulmonary disease (39 mm Hg 95% CI 35 to 42; $p < 0.001$). Lower ETCO₂ levels predicted CHF, with an area under the Receiver Operating Characteristics Curve of 0.70 (95% CI 0.60 to 0.81). Using ETCO₂ < 40 mm Hg as a cut-off, the sensitivity for predicting heart failure was 93% (95% CI 88% to 98%), the specificity was 43% (95% CI 33% to 52%), the positive predictive value was 38% (95% CI 29% to 48%), and the negative predictive value was 94% (95% CI 89% to 99%).

Conclusions Lower levels of ETCO₂ were associated with CHF, and may serve as an objective diagnostic adjunct to predict this cause of dyspnoea in the prehospital setting.

INTRODUCTION

Differentiating between cardiac and obstructive causes is an important aspect of patient assessment in the setting of dyspnoea. However, many signs and symptoms overlap, making the proper diagnosis difficult.¹ Diagnosis frequently depends on chest radiographs or serum N-terminal pro-brain natriuretic peptide (BNP) depending on the clinical setting.¹ Prehospital providers are unlikely to have such diagnostic tests available to them, so a fast, non-invasive mechanism to objectively differentiate between these two common causes for dyspnoea could provide essential information.

Exhaled end-tidal carbon dioxide (ETCO₂), a continuous variable that is determined by basal metabolic rate, cardiac output, and ventilation, can be measured non-invasively by capnography and may provide valuable information assessing acute dyspnoea.² Obstructive pulmonary disease (COPD/

Key messages

What is already known on this subject

It is difficult for prehospital providers to determine between cardiac and obstructive pulmonary causes of dyspnoea. Evidence suggests that end-tidal carbon dioxide (ETCO₂), which can be measured non-invasively, may be significantly lower in dyspnoeic patients suffering from congestive heart failure.

What this study adds

This study suggests that lower prehospital ETCO₂ levels may predict a diagnosis of congestive heart failure upon hospital admission. This may provide an objective measure for field evaluation of patients with dyspnoea.

asthma) is characterised in part by hypoventilation, retention of carbon dioxide and high PaCO₂, while pulmonary oedema caused by congestive heart failure (CHF) is characterised by, in part, by poor alveolar oxygen exchange and increased ventilation.¹ In a small prospective study, Brown *et al*³ demonstrated that ETCO₂ levels were significantly lower in emergency department patients with CHF compared to those with obstructive pulmonary disease. Additionally, using an algorithm including ETCO₂ levels in addition to serum BNP has been shown to improve appropriate diagnosis by physicians in the prehospital setting.⁴

The purpose of this study is to investigate the relative clinical value of prehospital ETCO₂ and oxygen saturation (SPO₂) measurements as mechanisms to differentiate between obstructive pulmonary and cardiac causes of dyspnoea. We hypothesise that lower prehospital ETCO₂ levels may predict CHF versus obstructive pulmonary disease.

METHODS

Design and setting

We conducted a retrospective cohort study among patients transported by a single emergency medical services (EMS) agency to a single hospital during a two-and-a-half-year period from January 2009 through July 2011 in Orange County, Florida. The institutional review board at the participating hospital approved the study protocol.

We evaluated the records of all adult patients (≥ 18 years) who had prehospital ETCO₂ recorded who were transported to Orlando Regional



CrossMark

To cite: Hunter CL,
Silvestri S, Ralls G, *et al*.
Emerg Med J 2015;**32**:453–
456.

Medical Center (ORMC), and were subsequently diagnosed with acute dyspnoea caused by obstructive pulmonary or cardiac disease. During the study period, the standard practice for the participating EMS agency was to record ETCO₂ level as part of the initial set of vital signs in patients requiring ALS. Exclusion criteria included patient refusal to consent to standard therapy and interventions, paediatric patients (<18 years old), and patients without recorded prehospital ETCO₂. Orange County, Florida is an urban/suburban region with a population of approximately one million individuals. ORMC is a Level One trauma centre with an ED volume of approximately 70 000 visits per year.

Data collection

Initial out-of-hospital vital signs documented by first-arriving EMS personnel including RR, systolic BP (SBP), diastolic BP (DBP), pulse (P), oxygen saturation (SPO₂), and ETCO₂ were obtained using LIFEPAK 12 multiparameter defibrillator/monitors. Prehospital measurement of ETCO₂ is a standard practice in Orange County, and is performed by paramedics following protocols. ETCO₂ was measured via microstream capnography using LIFEPAK 12 devices (PhysioControl, Redmond, Washington, USA). Microstream capnography is an ETCO₂ sampling method using molecular correlation spectroscopy applicable to intubated and non-intubated patients. ETCO₂ was recorded when capnographic wave peaks were at a constant end-tidal for 3–5 respirations as directed by protocol.

Patient age, gender, ETCO₂, RR, SBP, DBP, P and SPO₂ were obtained from prehospital run reports. Principle diagnosis of obstructive pulmonary disease, including chronic obstructive pulmonary disease (COPD) or asthma, and cardiac disease, including CHF or pulmonary oedema, were obtained from the hospital chart and defined by International Classes of Disease, ninth edition (ICD-9) codes. The ICD-9 code for the patient's *principle diagnosis* from the specific admission was used, so patients with a history of both types of disease were placed only in the group whose exacerbation caused the admission. ICD-9 codes used included 491 and 493 for obstructive disease, and ICD-9 428 for CHF. Mortality and admission to hospital or intensive care unit (ICU) were also obtained from the hospital chart. Records were linked by manual archiving of EMS and hospital data.

Analysis

Data were described using means and proportions with 95% CIs. Data were assessed for variance and distribution, and comparisons between CHF and obstructive pulmonary disease were performed using Fisher's Exact test, and independent sample t tests with pooled or separate variance, as appropriate. The accepted normal range of ETCO₂ is 30–40 mm Hg, so for sensitivity, specificity, positive/negative predictive values, and likelihood ratios, data was analysed using an ETCO₂ <40 mm Hg as a cut-off. Receiver Operating Characteristics curves (ROC curves) were constructed to assess the performance of ETCO₂ and SPO₂ for predicting CHF. As a statistical measure, the area under the ROC curve measures the accuracy of a test—an area of 1 or –1 represents a perfect test, an area of 0.50 represents a poor test. Significance was set at 0.05. Data were analysed using STATA (StataCorp, College Station, Texas, USA).

RESULTS

There were 106 patients with a diagnosis of asthma/COPD or CHF who had prehospital ETCO₂ levels measured during the study period: 75 patients with a diagnosis of asthma/COPD and

31 with CHF. No patients were intubated prior to hospital arrival. The mean age was 59 years (SD20), 58 (55%) were women, 82 (77%) were admitted to the hospital, 5 (5%) were admitted to the ICU, and 1 (1%) died (see [table 1](#)). Patients with CHF were older (69 vs 56 years old, $p=0.003$), and more likely to be admitted to the hospital (68% vs 100%, $p=0.002$). Patients diagnosed with CHF also had higher RRs (31 vs 26 bpm, $p=0.046$) and DBP (98 vs 86 mm Hg, $p=0.009$) than those with COPD/asthma (see [table 1](#)). ETCO₂ levels were significantly lower in patients with cardiac causes of dyspnoea. Mean levels of ETCO₂ in patients with CHF were 31 mm Hg (95% CI 27 to 35 mm Hg) compared with 39 mm Hg (95% CI 35 to 42 mm Hg, $p<0.001$) for those diagnosed with COPD/asthma (see [table 1](#)). There was no significant difference in the mean SPO₂ levels in each group; 93% (95% CI 92% to 95%) in COPD/asthma, and 93% (95% CI 90% to 96%, $p=0.83$) in CHF.

Using ETCO₂ <40 mm Hg as a cut-off for hypoventilation (see [figure 1](#)), the sensitivity for predicting CHF was 93% (95% CI 88% to 98%), the specificity was 43% (95% CI 33% to 52%), the positive predictive value was 38% (95% CI 29% to 48%), and the negative predictive value was 94% (95% CI 89% to 99%). The positive Likelihood Ratio was 1.63 (95% CI 1.31 to 2.03), and the negative Likelihood Ratio was 0.15 (95% CI 0.04 to 0.60).

To evaluate the usefulness of non-invasive measures for oxygenation (SPO₂) and ventilation (ETCO₂) in the prehospital setting, ROC curves were constructed to determine the accuracy of ETCO₂ and SPO₂ in predicting CHF. The area under the ROC curve for predicting CHF was 0.70 (95% CI 0.60 to 0.81) for ETCO₂ and 0.50 (95% CI 0.37 to 0.62) for SPO₂ (see [figure 2](#)).

DISCUSSION

This study demonstrates that prehospital ETCO₂ levels are lower in patients presenting with dyspnoea caused by heart failure, as compared with obstructive pulmonary disease, and that ETCO₂ outperforms SPO₂ at predicting CHF in this patient population. Prior reports have similarly found that ETCO₂ is lower in patients with CHF versus those with obstructive pulmonary disease,³ and have described using ETCO₂ in conjunction with serum BNP to improve diagnostic accuracy in the prehospital setting.⁴ ETCO₂ has also been described as having prognostic value in CHF patients at rest⁵ and undergoing exercise testing.⁶ The use of capnography to measure ETCO₂ may help differentiate obstructive versus pulmonary causes of dyspnoea in an environment where chest radiographs and serum BNP levels are not available.

ETCO₂ is a continuous variable that is determined by basal metabolic rate, cardiac output and ventilation, and abnormal levels may reflect derangement in perfusion, metabolism or gas exchange. Capnography is used for monitoring ventilation of sedated patients,⁷ evaluation of proper endotracheal tube placement,⁸ and confirming return of spontaneous circulation during cardiopulmonary arrest.⁹ Recent studies have suggested low ETCO₂ levels are associated with disease severity and mortality in shock,¹⁰ sepsis,¹¹ metabolic disturbances¹² and trauma.¹³ Therefore, the lower ETCO₂ levels found in CHF may be caused by a number of different factors, including increased ventilation or decreased perfusion. In the current study, patients with CHF also had an increased RR, suggesting that the decrease in ETCO₂ may have been secondary to hyperventilation. The relationship between ETCO₂ and CHF may be multifactorial, since the combination of factors that produce ETCO₂

Table 1 Characteristics

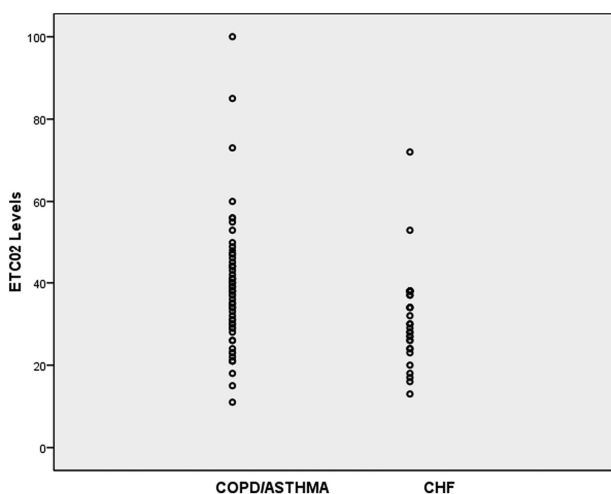
| | Total N=106 | COPD/asthma N=75 | CHF N=31 | Significance p value |
|---------------------------|------------------|---------------------|------------------|-------------------------|
| Age | 59 (SD20) | 56 (SD20) | 69 (SD16) | 0.003 |
| Gender (% male) | 48 (45) | 35 (46) | 13 (42) | 0.675 |
| Admitted to hospital (%) | 82 (77) | 52 (68) | 31 (100) | 0.002 |
| Admitted to ICU (%) | 5 (5) | 3 (4) | 2 (6) | 0.628 |
| Mortality (%) | 1 (1) | 1 (1) | 0 (0) | 0.999 |
| Respiratory rate (95% CI) | 28 (26 to 30) | 26 (24 to 28) | 31 (27 to 35) | 0.046 |
| Pulse (95% CI) | 103 (98 to 108) | 103 (98 to 108) | 105 (95 to 115) | 0.647 |
| Systolic BP (95% CI) | 149 (142 to 156) | 146 (139 to 153) | 158 (144 to 172) | 0.105 |
| Diastolic BP (95% CI) | 89 (85 to 93) | 86 (82 to 90) | 98 (90 to 116) | 0.009 |
| ETCO2 (95% CI) | 36 (34 to 38) | 39 (35 to 42) | 31 (27 to 35) | <0.001 |
| SPO2 (95% CI) | 94 (93 to 95) | 93 (92 to 95) | 93 (90 to 96) | 0.83 |

CHF, congestive heart failure; COPD, chronic obstructive pulmonary disease; ICU, intensive care unit.

(metabolic rate, cardiac output, and ventilation) all might be deranged in the setting of heart failure.

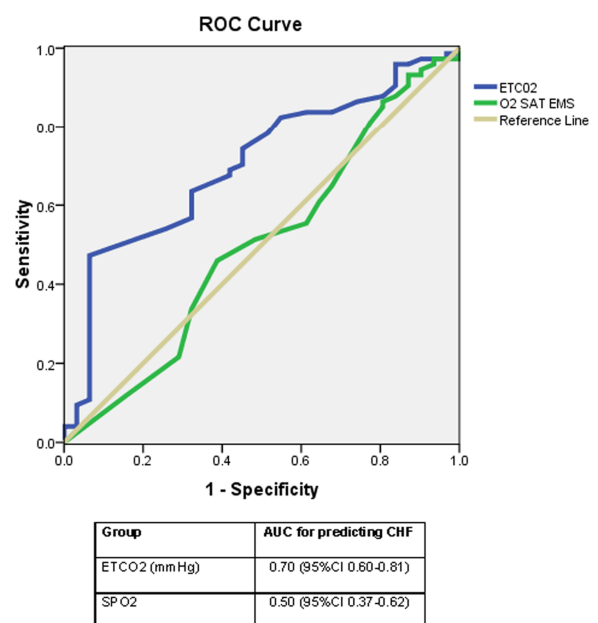
A primary physiologic cause of dyspnoea in obstructive pulmonary disease is hypoventilation and resulting hypercapnia.¹ The relationship between ETCO₂ and partial arterial carbon dioxide (PaCO₂) in the setting of dyspnoea has not been completely elucidated. Prior studies have shown that ETCO₂ may predict PaCO₂ in patients with asthma,¹⁴ and ED patients with acute dyspnoea.¹⁵ However, the accuracy of ETCO₂ to predict PaCO₂ in acute dyspnoea has been questioned.¹⁶ In the current study, we did not assess PaCO₂ since we were evaluating prehospital ETCO₂ prior to hospital arrival, and few of the enrolled patients had ABG analysis performed in the ED.

Since elevated ETCO₂ likely reflects hypercapnia, we examined the relationship of lower levels with CHF. A prior report suggested ED patients with ETCO₂>37 mm Hg are unlikely to have CHF.³ Here, we found ETCO₂ of less than 40 mm Hg had a high sensitivity, negative predictive value, and negative likelihood ratio, suggesting patients with dyspnoea and lower ETCO₂ levels are more likely to have a cardiac aetiology. These findings demonstrate potential for prehospital providers to discriminate between causes of dyspnoea.

**Figure 1** Scatter plot of ETCO₂ distribution.

Using waveform capnography to assess patients with acute dyspnoea may provide information beyond the ETCO₂. Krauss *et al*¹⁷ demonstrated significant difference in the shape of the capnogram in obstructive disease versus those with normal and restrictive lung disease. It is possible that a combination of measurements including the ETCO₂, alveolar plateau elevation angle, or take-off angle of the ascending phase may further elucidate obstructive pulmonary disease from other causes of acute dyspnoea.

Non-invasive methods for distinguishing disease processes play an important role in prehospital medicine. Prior reports have found novel applications for sonography in prehospital patients with acute dyspnoea, demonstrating high sensitivity for pleural effusions in patients with CHF.¹⁸ In the future, combining sonography with capnography may provide a method for determining appropriate treatment in the field.

**Figure 2** Receiver Operating Characteristics (ROC) curve for predicting congestive heart failure (CHF).

Limitations

There are several limitations to this study. This study was performed retrospectively and, thus, is subject to selection bias. The relatively small sample size may have contributed to the inability to define an ETCO₂ cut-off with higher specificity and positive predictive value. This study was conducted using the data from a single EMS agency transported to a single hospital, and may not be applicable to all settings. Per protocol, ETCO₂ was collected by paramedics only in patients requiring ALS care, so patients deemed to require only basic life support in the pre-hospital setting were excluded.

CONCLUSIONS

Lower levels of prehospital ETCO₂ were associated with having CHF, and ETCO₂ was better than SPO₂ in distinguishing between obstructive pulmonary and cardiac disease. This suggests that ETCO₂ could be a valuable tool for EMS providers assessing respiratory distress.

Contributors CLH, SS, GR and LP planned the study. CLH and SS obtained the data and performed chart review. CLH and LP performed data analysis. CLH, SS, GR and LP created the manuscript. CLH submitted the manuscript, and is responsible for the overall content as the guarantor.

Competing interests None.

Ethics approval ORMC IRB.

Provenance and peer review Not commissioned; externally peer reviewed.

REFERENCES

- Hawkins NM, Petrie MC, Pardeep SJ, *et al.* Heart failure and chronic obstructive pulmonary disease: diagnostic pitfalls and epidemiology. *Eur J Heart Failure* 2009;11:130–9.
- Ward KR, Yealy DM. End-tidal carbon dioxide monitoring in emergency medicine, part 1: basic principles. *Acad Emerg Med* 1997;5:628–36.
- Brown LH, Gough JE, Seim RH. Can quantitative capnometry differentiate between cardiac and obstructive causes of respiratory distress? *Chest* 1998;133:323–6.
- Klemen P, Golub M, Grmec S. Combination of quantitative capnometry, N-terminal pro-brain natriuretic peptide, and clinical assessment in differentiating acute heart failure from pulmonary disease as cause of acute dyspnea in prehospital emergency setting: Study of diagnostic accuracy. *Croat Med J* 2009;50:133–42.
- Arena R, Peberdy MA, Myers J, *et al.* Prognostic value of resting end-tidal carbon dioxide in patients with heart failure. *Int J Cardiol* 2006;109:351–8.
- Arena R, Guazzi M, Myers J. Prognostic value of end-tidal carbon dioxide during exercise testing in heart failure. *Int J Cardiol* 2007;117:103–8.
- Deitch K, Miner J, Chudofsky CR, *et al.* Does end tidal CO₂ monitoring during emergency department procedural sedation and analgesia with propofol decrease the incidence of hypoxic events? A randomized, controlled trial. *Ann Emerg Med* 2010;55:258–64.
- Silvestri S, Ralls GA, Krauss B, *et al.* The effectiveness of out-of-hospital use of continuous end-tidal carbon dioxide monitoring on the rate of unrecognized misplaced intubation within a regional emergency medical services system. *Ann Emerg Med* 2005;45:497–03.
- Sanders AB, Kern KB, Otto CW, *et al.* End-tidal carbon dioxide monitoring during cardiopulmonary resuscitation. A prognostic indicator for survival. *JAMA* 1989;262:1347–54.
- Kheng CP, Rahman NH. The use of end-tidal carbon dioxide monitoring in patients with hypotension in the emergency department. *Inter J Emerg Med* 2012;5:31–8.
- Hunter CL, Silvestri S, Dean M, *et al.* End-tidal carbon dioxide is associated with mortality and lactate in patients with suspected sepsis. *Am J Emerg Med* 2013;31:64–71.
- Kartal M, Oktay E, Rinnert S, *et al.* ETCO₂: a predictive tool for excluding metabolic disturbances in nonintubated patients. *Am J Emerg Med* 2011;29:65–9.
- Deakin CD, Sado DM, Coats TJ, *et al.* Prehospital end-tidal carbon dioxide concentration and outcome in major trauma. *J Trauma* 2004;57:65–8.
- Corbo J, Bijur P, Lahn M, *et al.* Concordance between capnography and arterial blood gas measurements of carbon dioxide in acute asthma. *Ann Emerg Med* 2005;46:323–7.
- Cinar O, Acar YA, Arziman I, *et al.* Can mainstream end-tidal carbon dioxide measurement accurately predict the arterial carbon dioxide level of patients with acute dyspnea in ED. *Am J Emerg Med* 2012;30:358–61.
- Deleme SD, Freund Y, Renault R, *et al.* Concordance between capnography and capnia in adults admitted for acute dyspnea in an ED. *Am J Emerg Med* 2010;28:711–14.
- Krauss B, Deykin A, Lam A, *et al.* Capnogram shape in obstructive lung disease. *Anesth Analg* 2005;100:884–8.
- Neesse A, Jerrentrup A, Hoffmann S, *et al.* Prehospital chest emergency sonography trial in Germany: a prospective study. *Eur J Emerg Med* 2012;19:161–6.