

TITLE: DIFFERENTIATING ESOPHAGEAL FROM TRACHEAL CAPNOGRAMS

AUTHORS: M.L. Good, M.D., J.H. Modell, M.D., W. Rush, B.A.

AFFILIATION: Department of Anesthesiology, University of Florida College of Medicine, Gainesville, Florida 32610-0254

Introduction. Capnography is an important method of differentiating between tracheal and esophageal intubation. Capnograms with tracheal characteristics have been reported following esophageal intubation (1). To better characterize the esophageal capnogram, we used an *in-vivo* canine model and an *in-vitro* mechanical model to simulate gastric distention with CO₂-containing gas and subsequent esophageal intubation.

Methods. The animal protocol was approved by the University Animal Care and Use Committee. Anesthesia was induced in a fasted adult mongrel dog with thiopental. The trachea was intubated and anesthesia was maintained with halothane (0.75-1.25%) in O₂. Controlled mechanical ventilation was titrated to an end-tidal CO₂ (ETCO₂) of 5 ± 0.25%. Because the Valve of His prevents gas distending a dog's stomach from refluxing into the esophagus, esophageal intubation was simulated by placing a second endotracheal tube (ETT) into the stomach through a gastrostomy. A catheter-tip pressure transducer and a 10-ga catheter were placed through separate gastrostomies, and the abdomen was surgically repaired. The tracheal and intragastric ETTs were each connected to separate circle breathing circuits and mechanical ventilators. CO₂ concentration in each circuit was measured at the Y-piece by separate capnographs. With the intragastric ETT clamped, the stomach was distended by infusing 1000 cc of 5% CO₂ through the intragastric catheter. Esophageal intubation was simulated by simultaneously turning off the ventilator attached to the tracheal ETT, turning on the ventilator attached to the intragastric ETT, and removing the clamp from the intragastric ETT. The capnograms from both breathing circuits were simultaneously recorded. The experiment was repeated using 10% CO₂ and different volumes of gas. Esophageal intubation was also simulated using a mechanical stomach model (2). The stomach was filled with 5% CO₂ until intragastric pressure equaled lower esophageal sphincter pressure (LESP). Gastric ventilation was initiated through an esophageally-placed ETT. CO₂ concentration was recorded continuously at the Y-piece. Studies were conducted with different LESP and different stomach compliances. Using the mechanical model, we also examined the volume of gas and the concentration of CO₂ that might actually be anticipated in the stomach. After achieving steady-state mask ventilation of the lungs (ETCO₂ = 5 ± 0.25%), laryngospasm was simulated by cross-clamping the trachea. Subsequent ventilations were delivered to the stomach. The volume of gas and concentration of CO₂ in the stomach were recorded. Studies were carried out with different durations of laryngospasm and using face masks having different deadspace volumes.

Results. In both the canine and mechanical models, the "exhaled" CO₂ concentration decreased rapidly following simulated esophageal intubation (Table). The capnograms recorded (Figs. 1 and 2)

were much different than the typical tracheal capnogram. While changes in gastric CO₂, gastric volume, LESP and stomach compliance affected the rate of CO₂ clearance, the characteristic esophageal capnogram showing a stepwise reduction in CO₂ with each succeeding breath was observed under all study conditions in both models. When laryngospasm was simulated during mask ventilation, one gastric tidal volume resulted in a CO₂ concentration of 3.0%, and additional tidal volumes further decreased this value. Decreasing the mask deadspace volume decreased the amount of gastric CO₂.

Discussion. While CO₂ may be detected for several breaths following esophageal intubation, the esophageal capnogram is much different than a normal tracheal capnogram; predictable CO₂ wash-out is observed with gastric ventilation. The difference between a tracheal and an esophageal capnogram is detectable after two "breaths," and is clearly evident after three. Thus, capnography remains an excellent clinical tool for differentiating esophageal from tracheal intubation.

References.

1. Ping STS: Anesth Analg 66:483, 1987
2. Melker RJ, Banner MJ: Ann Emerg Med 14:397, 1985

Table. "Exhaled" CO₂ (%)--Canine Model

Breath Number	5% CO ₂ * 1000 cc	10% CO ₂ * 1000 cc	5% CO ₂ † 2000 cc	5% CO ₂ † 3000 cc
1	3.1 ± .46	6.2 ± .81	4.9	5.0
2	1.7 ± .20	3.2 ± .37	2.6	3.5
3	.9 ± .08	1.4 ± .33	1.6	2.0
4	.5 ± .04	.7 ± .23	.8	1.1
5	.3 ± .04	.4 ± .11	.4	.6
6	.2 ± .04	.2 ± .09	.3	.3
7	.1 ± .04	.1 ± .04	.1	.2
8	.0	.0	.0	.1

*Mean ± S.D., N = 4; †N = 1.

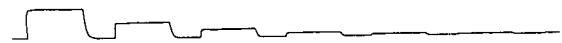


Fig. 1. Esophageal Capnogram--Canine Model



Fig. 2. Esophageal Capnogram--Mechanical Model