Transcutaneous Oximetry Testing and Interpretation

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Tissue Oximetry & Hyperbaric Wound Referrals

Primary Training in Hyperbaric Medicine

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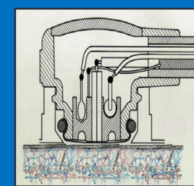
Transcutaneous Oximetry

Non-invasive physiologic assessment of skin microcirculatory oxygen

~ in contrast to standard hemodynamic & anatomic testing



Low tcpO2 Predicts Abnormal Arteriography

96% of 66 limbs with tcpO2 < 30mmHg had abnormal arteriogram

Ballard JL, *et al.* 1995

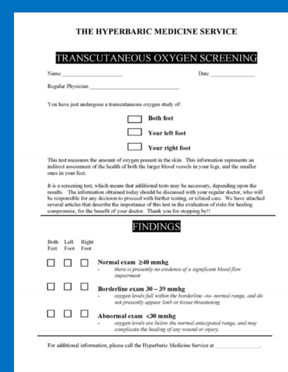
tcpO2 <30mmHg reliable indicator of need for arteriography, with 98% limbs showing significant disease

Bunt TJ, *et al.* 1996

Risk factors for diabetic amputation

Pathophysiologic Factor	Odds Ratio
Cutaneous circulation *$tcpO_2$ <20 vs. >40mmHg*	161
Peripheral arterial circulation *Doppler ABI <0.45 vs. 0.70*	55.8
Neuropathy *lacking distal vibratory sense*	15.1
Ulcers become infected	10.1

Reiber GE, *et al.* 1992
Ann. Int. Med;117:97-105



THE HYPERBARIC MEDICINE SERVICE

TRANSCUTANEOUS OXYGEN SCREENING

Name ____________ Date ____________

Regular Physician ____________

You have just undergone a transcutaneous oxygen study of:

☐ **Both feet**
☐ **Your left foot**
☐ **Your right foot**

This test measures the amount of oxygen present in the skin. This information represents an indirect assessment of the health of both the larger blood vessels in your legs, and the smaller ones in your feet.

It is a screening test, which means that additional tests may be necessary, depending upon the results. The information obtained today should be discussed with your regular doctor, who will be responsible for any decision to proceed with further testing, or related care. We have attached several articles that describe the importance of this test in the evaluation of risks for healing compromise, for the benefit of your doctor. Thank you for stopping by!!

FINDINGS

Both Feet	Left Foot	Right Foot	
☐	☐	☐	**Normal exam ≥40 mmhg** - *there is presently no evidence of a significant blood flow impairment*
☐	☐	☐	**Borderline exam 30 – 39 mmhg** - *oxygen levels fall within the borderline –to- normal range, and do not presently appear limb or tissue threatening*
☐	☐	☐	**Abnormal exam <30 mmhg** - *oxygen levels are below the normal anticipated range, and may complicate the healing of any wound or injury.*

For additional information, please call the Hyperbaric Medicine Service at ____________.

The tcpO2 Hyperbaric Algorithm

Is wound healing complicated by hypoxia?

Is any such hypoxia reversible?

Is patient responding to HBO therapy?

Has a therapeutic endpoint been reached?

What Represents a Normal Lower Extremity Value?

Dermal oxygenation mapped in healthy volunteers

Eickhoff JH & Engell HC 1981
Wyss CR, et al. 1981
Franzeck UK, et al. 1982
Sheffield, PJ & Workman WT, 1985
Jonsson K, et al. 1987
Orenstein A, et al. 1988
Dowd GS, et al. 1993(a)
Dowd GS, et al. 1993(b)

a 'normal' tcpO2 falls within a range of values (53-92 mmHg)

reasonable to conclude that normal values exceed 50 mmHg

What Values Considered Suboptimal?

Values > 40 mmHg representative of adequately oxygenated tissue

~ *normal oxidative function*

Basic/clinical data suggests threshold range of < 35-40 mmHg as sub-optimal for O2 dependent wound healing

One definition of 'critical limb ischemia' < 30mmHg

~ *degree of adverse influence increases as values decrease*

What About Any Control Sites?

Left second intercostal space grossly reflects 'central' oxygenation….*normal range 65-90mmHg (1.0 ATA)*

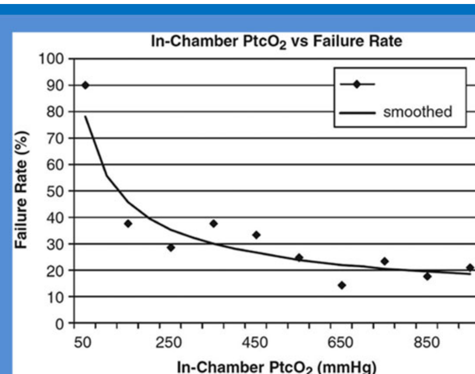
regional perfusion index (RPI)

Contra-lateral reference sites may represent poor comparison of normal to diseased tissue

Normobaric 100% Oxygen Challenge

Response ranges

- > 300 mmHg…*regional large vessel disease unlikely*
- 200-300 mmHg…*minimal regional large vessel disease*
- 100-199 mmHg…*non-limb threatening degree of arterial disease*
- 51-99 mmHg…*significant large vessel; further arterial study*
- < 50 mmHg…*high grade vascular insufficiency; further arterial study*



Fife CE, *et al.* 2002
Wound Repair Regen;10:198-207

Systemic Factors Influencing tcpO2

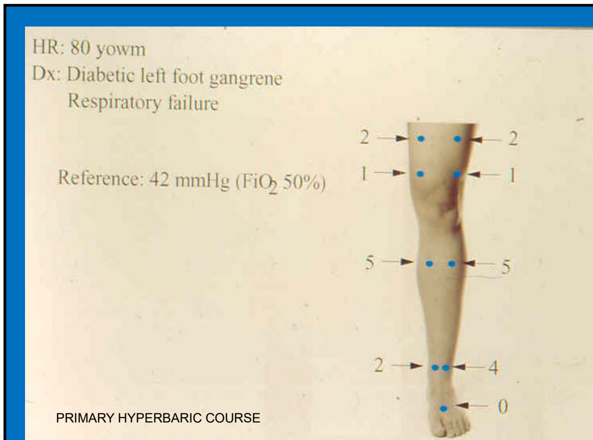
Pulmonary & cardiac function; oxygen content

Central & peripheral vascular perfusion

Smoking; caffeine ingestion

Vaso-active pharmacologic/other such substances

Environment (temperature /altitude)



Local Factors Influencing tcpO2

Obesity
Edema
Inflammation

Increased skin thickness
Cutaneous radiation tissue injury

Bony prominences

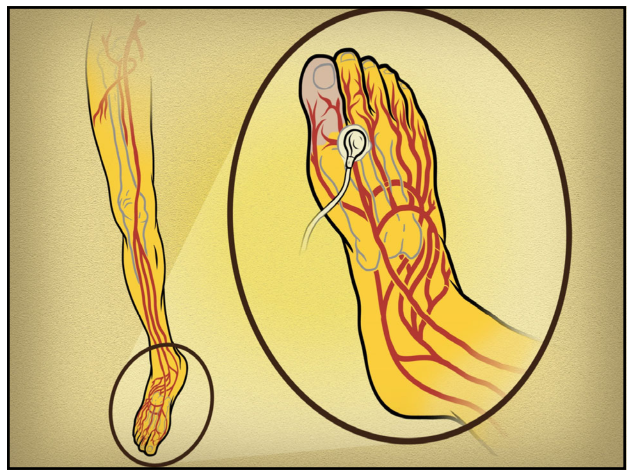
Poor skin preparation
Poor electrode attachment

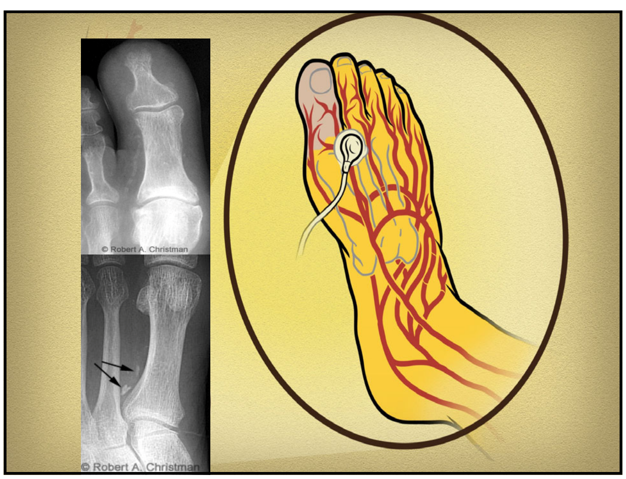
PRIMARY HYPERBARIC COURSE

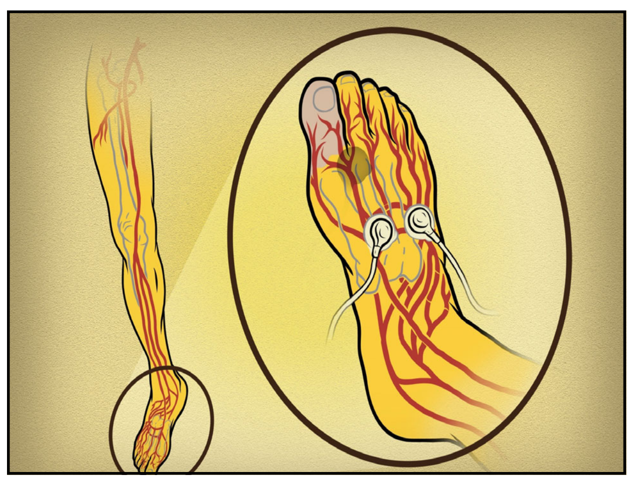
Site Selection; Anatomic Factors

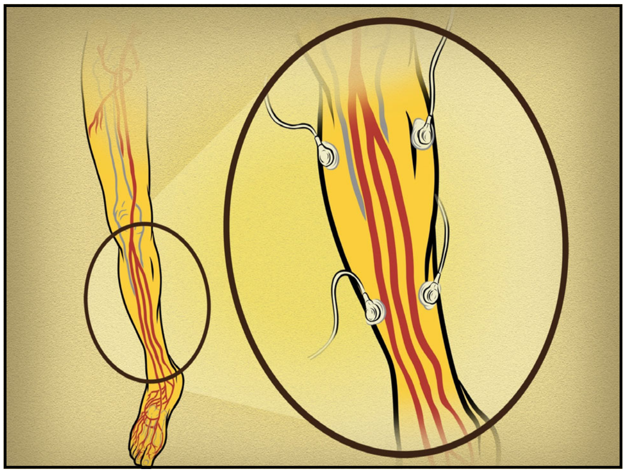
Sensor site selection straightforward enough if…

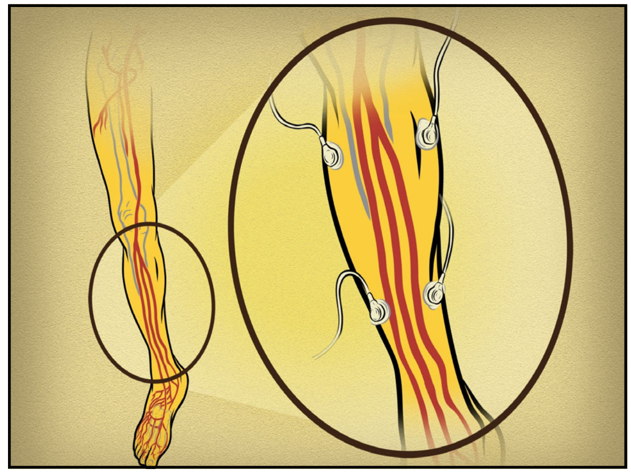
- Clear understanding of question in need of address
- Appreciate principal anatomic determinant that answers question
- Principal testing site(s) consistent with that determinant
- Any necessary secondary testing site(s) incorporated

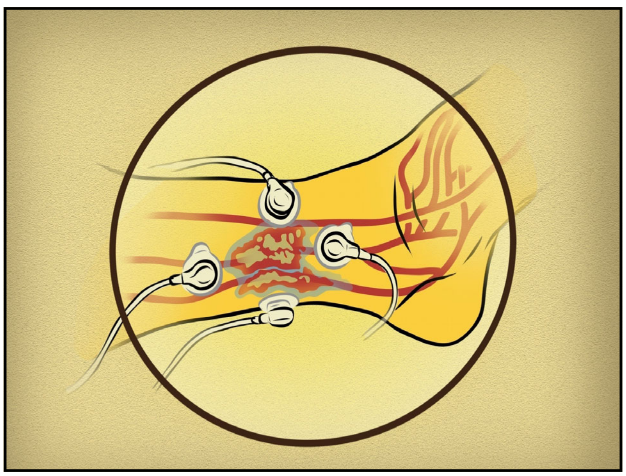


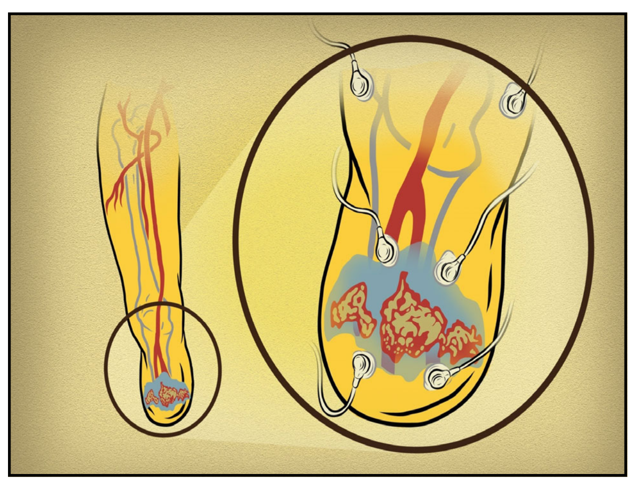












When To Delay Testing

Immediately post hemo-dialysis
Nutritive skin perfusion impaired during dialysis, sufficient in some cases to cause chest/cardiac & leg pain

~ significant $tcpO_2$ decreases in pts. with & without PVD

Weiss T, *et al.* 1998
Neph Dial Trans; 13

Markedly edematous tissue
Diffusion barrier between functioning capillaries & skin

Dooley J, *et al.* 1996
UHM;23(3): 167-174

Caffeine ingestion
Restrict caffeine-containing substances prior to testing

~ significant differences in healthy subjects, sufficient to screen out otherwise suitable candidates

Stephens M, *et al.* 1999
UHM;26(2): 93-97

Nicotine
Avoid any use for at least two hours prior to tissue oximetry

Jensen JA, *et al.* 1994
Arch Surg; 126:1131-1134

Supplemental oxygen administration
Absence of conversion factors

Post-operative $tcpO_2$ values

~ following successful limb revascularization

Several day delay exists from revascularization to significantly improved skin oxygenation
~ even 3 days postop, 5/11 pts still had values < 30 mmHg

Arroyo CI, *et al.* 2002
J Foot Ankle Surg 41(4)

"It takes 3-4 weeks after PTA for $tcpO_2$ values to reach optimal levels for wound healing"
~ "findings suggest that, when surgery can be delayed, best time to perform aggressive debridement/minor amputations is 3-4 weeks post PTA"

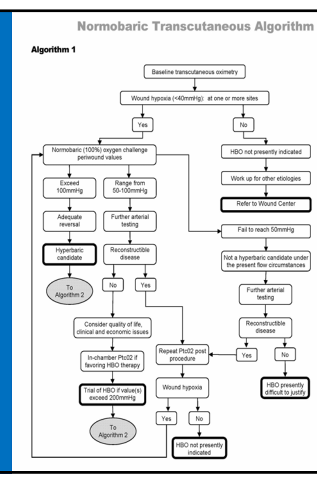
Caselli A, *et al.* 2005
Diabetes Medicine 22

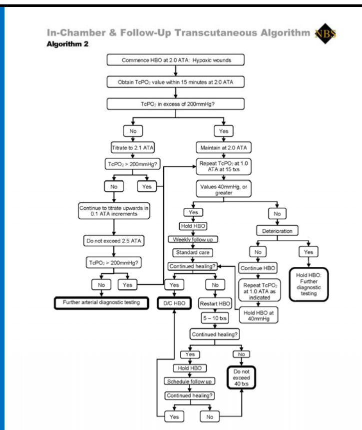
"$tcpO_2$ continued to increase up to 8 weeks after PTA, while ABI remained constant"
~ "perhaps revascularization in sparsely perfused areas causes increase in angiogenesis processes leading to an increase in capillary function?"

Pardo M, *et al.* 2015
British J Radiology 88

Possible Etiologies

- Post-operative edema
- Vasospasm, due to high pressures
- Ischemia-reperfusion injury
- Endothelial cell trauma
- Micro embolic events
- Effects of dye
- Angiogenesis processes





PRIMARY HYPERBARIC COURSE

tcpO2 useful tool for identifying diabetics with 'foot at risk'

disturbed microcirculation already present in clinically mild neuropathy

Zimny S. *et al.* 2001
Diabetes Care: 4(10)

tcpO2 predictive value best method for amputation level

Misuri A, *et al.* 2000
J. Cardiovasc. Surg 41(1)

Superiority in prediction of limb salvage post angioplasty

vs. ABI during BK angioplasties

Andrews KL, *et al.* 2013
Am J Phys Med Rehab;92(5)

PRIMARY HYPERBARIC COURSE

tcpO2 as predictor of outcome from HBO

~non-healing wounds & critical limb ischemia

- ✓ Non-reconstructable PVD (50%)
- ✓ Failed revascularization attempts
- ✓ Non-healing wounds post successful by-pass

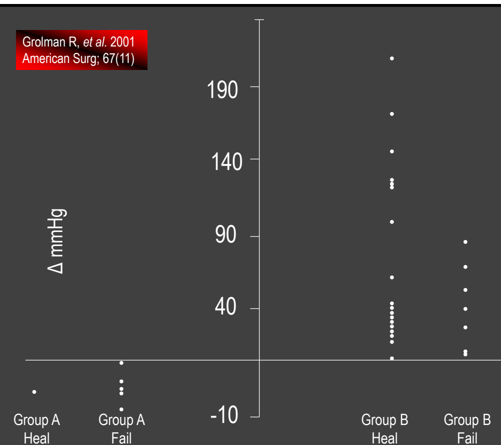
36 pts. screened and treated

Group A (9): baseline values < 10mmHg
~ O2 challenge: mean fall in value

Group B (27): baseline values > 10 mmHg
~ O2 challenge: mean increase of 76 mmHg

Grolman RE, *et al.* 2001
American Surgeon; 67(11)

Grolman R, *et al.* 2001
American Surg; 67(11)



PRIMARY HYPERBARIC COURSE

'We can predictably identify patients likely to benefit from HBO using tcpO2 at the time of initial evaluation'

Grolman RE, *et al.* 2001
American Surgeon; 67(11)

PRIMARY HYPERBARIC COURSE

Group A 'Healed'

Problem	Final Outcome
Toe gangrene……………………forefoot amputation	

Group B 'Healed' (O2 challenge < 100 mmHg)

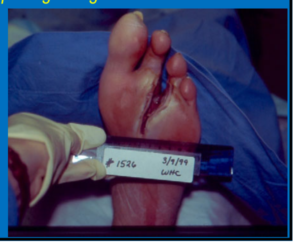
3 x Toe(s) gangrene…………….toe amputated	
3 x Toe ulcer(s)………………….toes amputated	
2 x Leg ulcer……………………..skin grafted	
1 x Foot ulcer …………………...Ray amputation	
1 x Forefoot gangrene…………..forefoot amputation	
1 x Non-healing forefoot amputation….skin grafted	

Case Study

56 yo DM male, for evaluation & tx. recommendations. Presents with non-healing left third toe Ray revision

present wound care; H_2O_2 irrigation, wet to damp dressings

PMH significant for right BKA & LLE by- pass grafting



	21% O_2	100% O_2
Medial Proximal Calf	64	298
Lateral Proximal Calf	58	241
Medial Distal Calf	61	288
Lateral Distal Calf	64	284
Mid-Dorsum	48	229/164
Proximal 1st-2nd Digits	54	285
Proximal 4th-5th Digits	56	336

~impression

Essentially normal exam

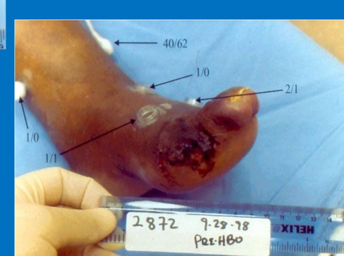
No indication for HBO therapy

Conservative care, d/c H_2O_2

74 year old DM underwent left great toe amputation secondary to ischemia; primary closure via rotational flap

F/U: tenderness at 1st metatarsal & plantar surfaces, erythema & edema; ischemic superior flap

Pt. admitted, further surgery contemplated, $tcpO_2$ ordered



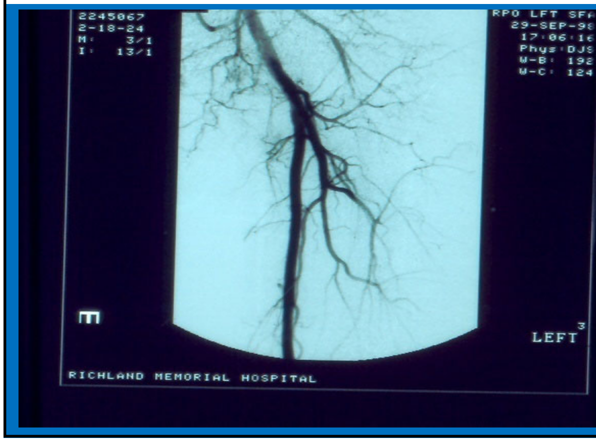
PRIMARY HYPERBARIC COURSE

Present level of amputation clearly compromised

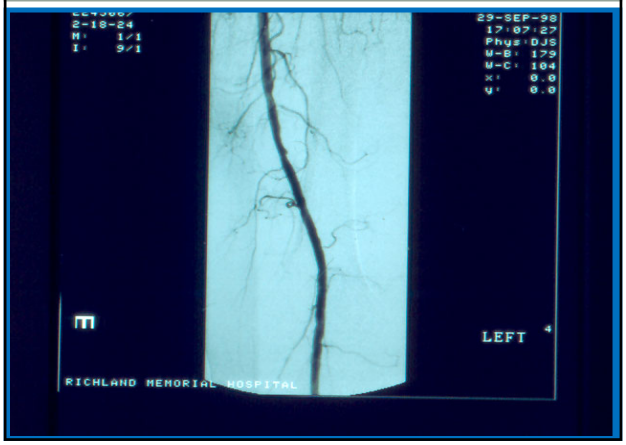
Revisions within foot unlikely to be successful given present perfusion

recommend further LLE arterial work-up

PRIMARY HYPERBARIC COURSE



PRIMARY HYPERBARIC COURSE



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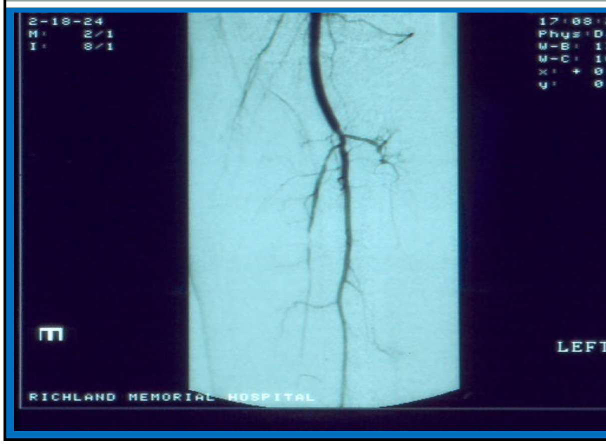
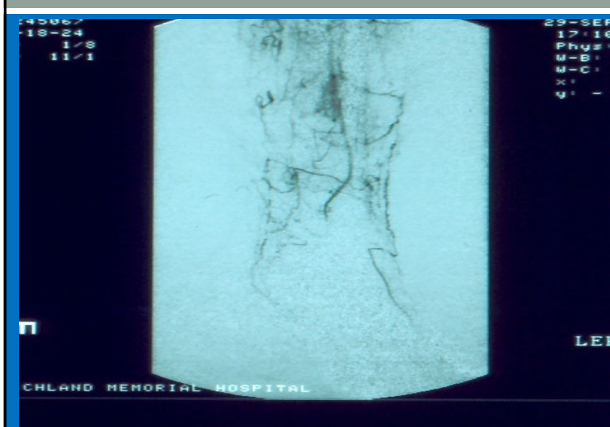


PRIMARY HYPERBARIC COURSE



PRIMARY HYPERBARIC COURSE

Operative exploration

Attempts made to identify grafting opportunities to foot

severely calcified vessels ruled out flow augmentation options

subsequently underwent BKA

PRIMARY HYPERBARIC COURSE

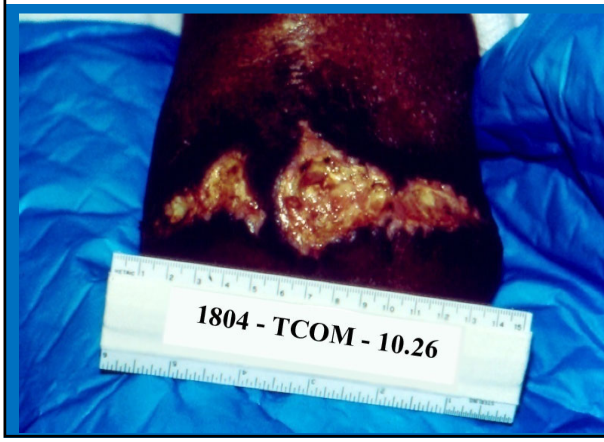
Case Study

83 yobf, referred for evaluation & treatment recommendations; presents with dehisced right BKA

surgery secondary to severe & non-reconstructable PVD

medical hx. includes IDDM; HTN; MI; CVA; CRF; DVT

PRIMARY HYPERBARIC COURSE



PRIMARY HYPERBARIC COURSE

	21% O2	100% O2
10 cm above knee, lateral	46	242
10cm above knee, medial	48	199
Lateral proximal wound	32	74
Medial proximal wound	28	96
Lateral stump	39	119
Medial stump	46	147
Lateral distal stump	38	69
Medial distal stump	26	57

PRIMARY HYPERBARIC COURSE

PRIMARY HYPERBARIC COURSE

PRIMARY HYPERBARIC COURSE

	21% O_2	100% O_2
Lateral proximal wound	51	122
Medial proximal wound	52	169
Lateral stump	45	120
Medial stump	47	114
Lateral distal stump	49	136
Medial distal stump	44	120

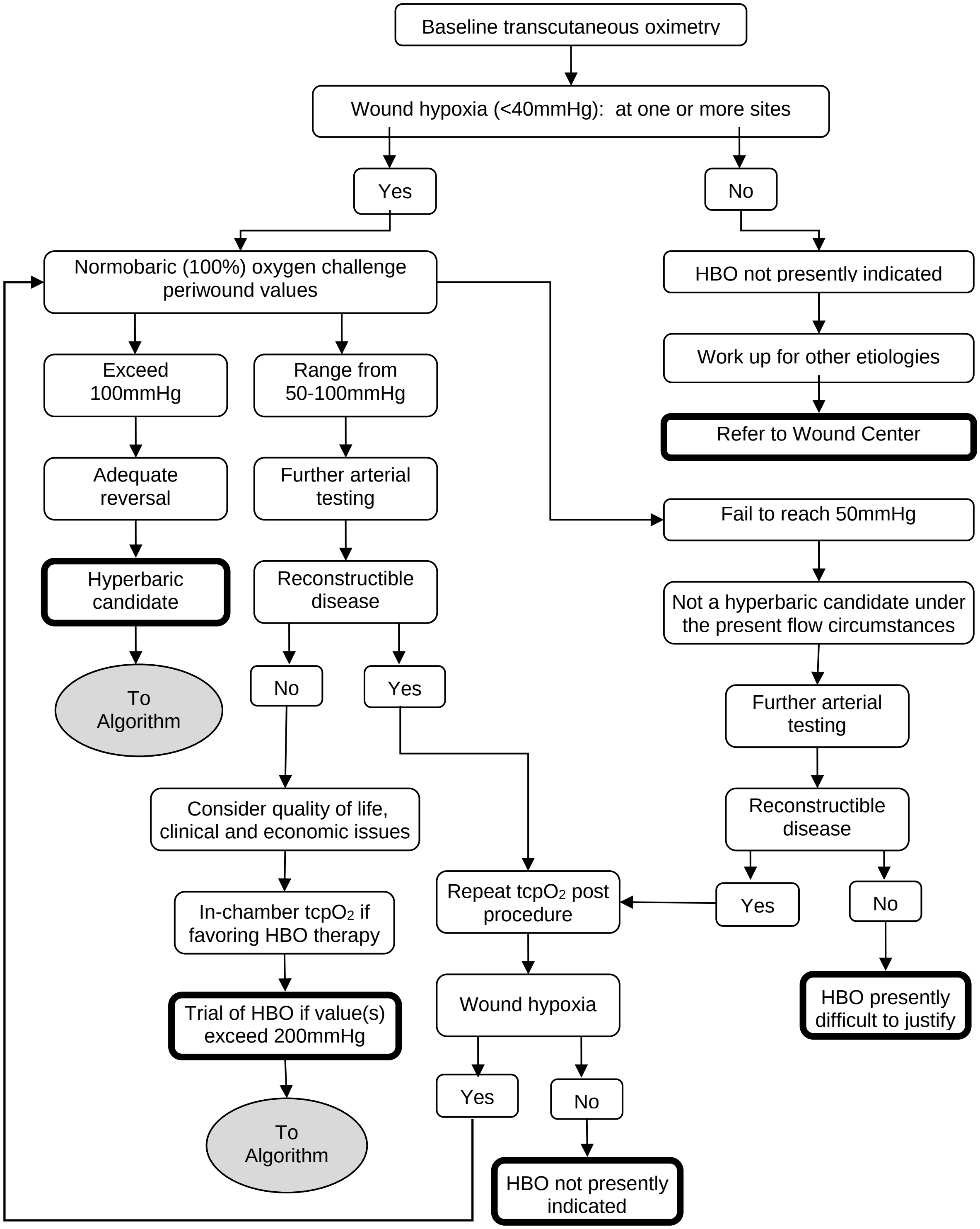
SUMMARY

On balance; using $tcpO_2$…

- Better guides pt. selection
- Optimizes case management
- c/w UHMS protocol guidance
- Better use of health care dollars
- Improved post-payment audit confidence

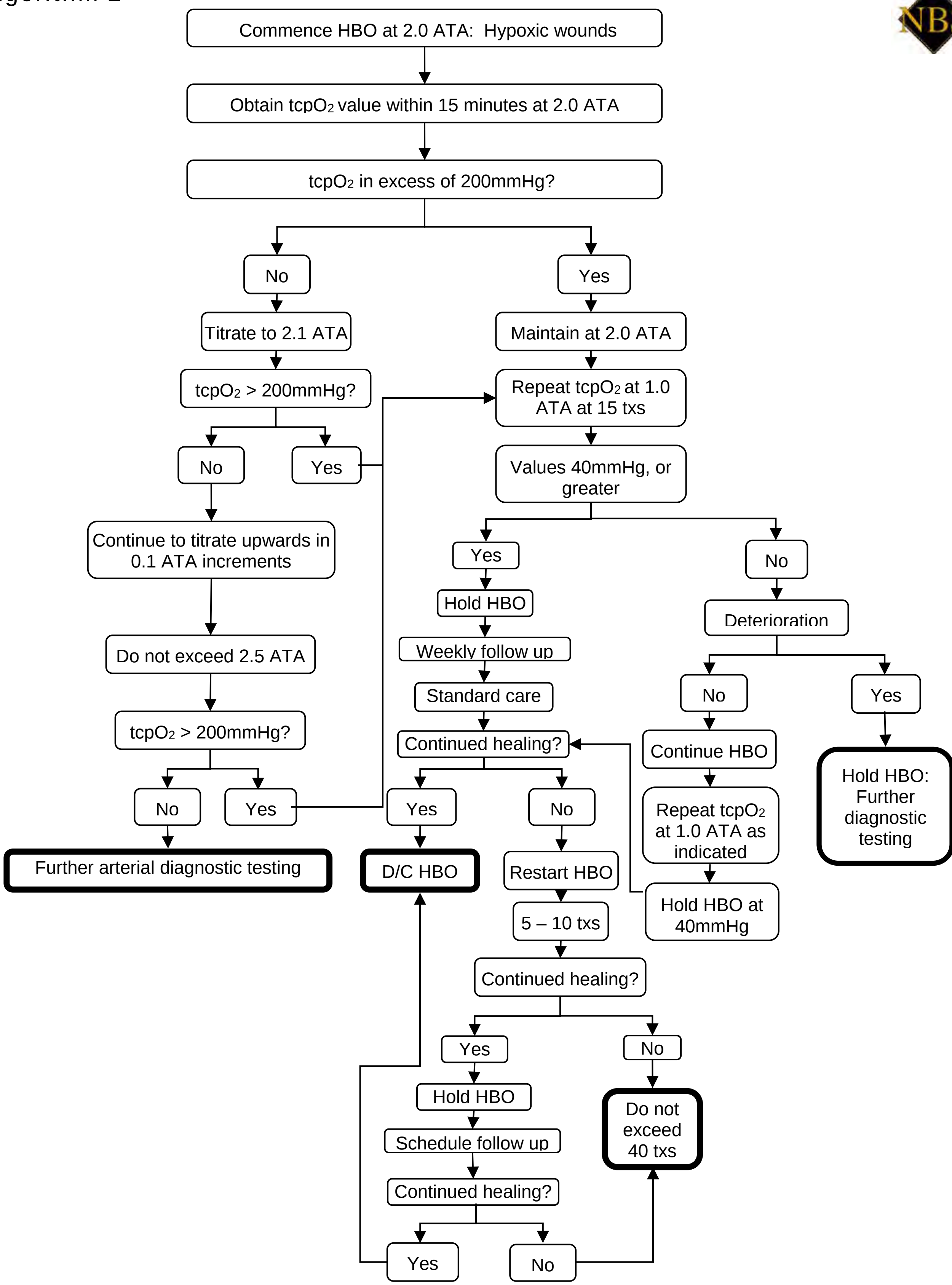
Normobaric Transcutaneous Algorithm

Algorithm 1



In-Chamber & Follow-Up Transcutaneous Algorithm

Algorithm 2



Transcutaneous Algorithms

Narrative and References

Hyperbaric wound healing referrals undergo a comprehensive work-up, including a detailed medical history, physical examination, and selected diagnostic testing. Baseline transcutaneous oxygen screening is followed up in an algorithmic manner in those patients whose risk-benefit ratio is in favor of a trial of hyperbaric oxygen therapy. Algorithm 2 addresses four essential questions:

I. Is wound healing complicated by hypoxia?

II. When present, is hypoxia reversible?

III. Is the patient responding to hyperbaric oxygen therapy?

IV. Has the patient reached a therapeutic endpoint?

I. Is wound healing complicated by hypoxia?

- Normal lower extremity transcutaneous oxygen values exceed 50mmHg* (1,2,3)
- Values ranging from 35-40mmHg, and higher, are considered sufficient to support oxygen-dependent wound healing (4,5,6)
- Values below this range represent a risk of healing compromise, the degree of which increases as value decreases (7,8)

II. When present, is hypoxia reversible?

For hyperbaric oxygen, a systemic method of dose delivery, to be effective, a certain degree of regional perfusion must be present.

- Breathing 100% oxygen at normobaric pressure, following the recording of a steady-state ambient air breathing value, evaluates regional arterial inflow capacity.
- Oxygen challenge values in excess of 300mmHg represent essentially uncompromised regional perfusion.
- Screening values in excess of approximately 100mmHg are suggestive of sufficient regional perfusion for limb viability, and reflect a suitable candidate for in-chamber follow-up transcutaneous oxygen testing.
- Screening values that fail to reach 100mmHg are consistent with a significant inflow abnormality, and warrant further arterial work-up. The decision to incorporate hyperbaric oxygen therapy into the treatment plan would be made on a case by case basis, in these circumstances and following decisions regarding any flow augmentation options, and as identified in Algorithm 1.

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* *when recorded at sea level pressure (760 mmHg)*

III. Is patient responding to hyperbaric oxygen therapy?

The above patient selection process does not predict outcome. It identifies those patients who have the physiologic capacity to deliver high oxygen tensions to the wound in question. There has been an unsuccessful effort to incorporate transcutaneous oximetry as an outcome predictor.[9,10,11,12,13] This should not be too surprising, given the complexity of such lesions, particularly in the diabetic patient. Improvement in ambient (21% O_2) transcutaneous oximetry over time probably remains the best indicator of therapeutic response.[11] Absence of increasing tissue oximetry values alerts the clinician to a potential non-responder. This should prompt evaluation of other possible impediments to wound repair, thereby avoiding an otherwise lengthy, unsuccessful and expensive course of therapy.

Transcutaneous oxygen reevaluation of the perilesional area should occur at 15 treatments, and in accordance with recommendations of the UHMS.

a. If values are increasing, the patient is considered a responder, and hyperbaric treatments are continued to Step IV.

b. If there has been no change, or if deterioration is evident, the patient undergoes further work-up for etiologies other than hypoxia. Hyperbaric oxygen therapy may be held at this point.

The goal of Step III is to reduce the likelihood of lengthy and ultimately unsuccessful courses of hyperbaric oxygen therapy.

IV. Has the patient reached the endpoint?

In this era of evidence-based medicine and cost containment, greater scrutiny is being directed at the health care delivery system in general, and those modalities not entirely entrenched within mainstream medical practice, in particular. It is important, therefore, that the decision to utilize hyperbaric oxygen therapy be mediated, in part, by its financial impact. In carefully selected patients, managed along algorithmic and evidence-based lines, hyperbaric oxygen therapy provides generally encouraging and clinically enduring outcomes, while reducing the patient's total health care cost. When used in a largely indiscriminate manner, it can be expensive and of questionable clinical value.

In terms of the wound referral, transcutaneous oxygen monitoring holds promise as an algorithmic management and cost containment tool. Well-oxygenated chronic wounds are directed to management strategies other than hyperbaric oxygenation. Hypoxic wounds that are the consequence of high-grade regional ischemia are likewise referred from the hyperbaricist for flow augmentation. In those patients entered into a hyperbaric treatment protocol, non-responders are identified early, rather than following many weeks, or even months, of treatment.

The final step is to identify when a course of hyperbaric oxygen therapy has produced sufficient angiogenesis to support further and spontaneous healing. It is not necessary, nor is it cost effective, to treat such wounds to complete resolution. Once the environment around the wound has been "normalized", and the patient converted to a locally host-competent state, hyperbaric oxygen can be stopped. Peri-wound transcutaneous oxygen values that reach or exceed 40 mmHg suggest adequate neovascularization has been formed. Typically, clinical evidence of healing responses will be apparent at this time. The wound may not be completely healed, however. At this point, hyperbaric oxygen therapy can be stopped. Standard wound care measures remain in force, and the patient is followed for continued healing responses. If the wound plateaus, or regresses, hyperbaric oxygen therapy is reinstituted. This is uncommon. In the setting for which this protocol is designed, the chronic and refractory skin ulceration, withholding hyperbaric therapy for one or two weeks is unlikely to represent a limb-threatening event. Should there be very significant improvement in wound quality, yet not all peri-wound values have reached the 40mmHg threshold, a one-week treatment hold, with the above evaluation schedule, would be appropriate.

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Hyperbaric Medicine Service
Transcutaneous Oximetry Assessment

Patient Label:

Patient Name ______________ Date ________ HBO # ________ Photo ☐

Interpreting Physician ______________ Clinician ______________

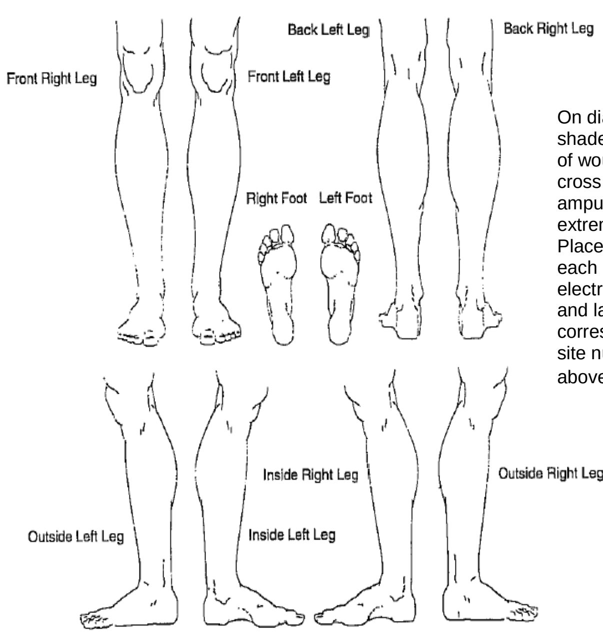
Pulse Oximetry ______ % Patient on ______ L of O2 BP ______ P ______ R ______ T ______

Diabetic: Yes No Dialysis: Yes No *If yes, last tx* Smoker: Yes No *If yes, last use*

Reference Site: ________ **mmHg on Room Air** **Reference Site Location:** **Chest** ☐ **Arm** ☐

Site 1	**Site 2**	**Site 3**
Location Description: ________	**Location Description:** ________	**Location Description:** ________
RPI: ________	**RPI:** ________	**RPI:** ________
Baseline Measurement on Air: ____ **mmHg**	**Baseline Measurement on Air:** ____ **mmHg**	**Baseline Measurement on Air:** ____ **mmHg**
1 Min on 100% O_2: ____ **mmHg**	**1 Min on 100% O_2:** ____ **mmHg**	**1 Min on 100% O_2:** ____ **mmHg**
2 Min on 100% O_2: ____ **mmHg**	**2 Min on 100% O_2:** ____ **mmHg**	**2 Min on 100% O_2:** ____ **mmHg**
3 Min on 100% O_2: ____ **mmHg**	**3 Min on 100% O_2:** ____ **mmHg**	**3 Min on 100% O_2:** ____ **mmHg**
4 Min on 100% O_2: ____ **mmHg**	**4 Min on 100% O_2:** ____ **mmHg**	**4 Min on 100% O_2:** ____ **mmHg**
5 Min on 100% O_2: ____ **mmHg**	**5 Min on 100% O_2:** ____ **mmHg**	**5 Min on 100% O_2:** ____ **mmHg**
10 Min on 100% O_2: ____ **mmHg**	**10 Min on 100% O_2:** ____ **mmHg**	**10 Min on 100% O_2:** ____ **mmHg**
Site 4	**Site 5**	**Site 6**
Location Description: ________	**Location Description:** ________	**Location Description:** ________
RPI: ________	**RPI:** ________	**RPI:** ________
Baseline Measurement on Air: ____ **mmHg**	**Baseline Measurement on Air:** ____ **mmHg**	**Baseline Measurement on Air:** ____ **mmHg**
1 Min on 100% O_2: ____ **mmHg**	**1 Min on 100% O_2:** ____ **mmHg**	**1 Min on 100% O_2:** ____ **mmHg**
2 Min on 100% O_2: ____ **mmHg**	**2 Min on 100% O_2:** ____ **mmHg**	**2 Min on 100% O_2:** ____ **mmHg**
3 Min on 100% O_2: ____ **mmHg**	**3 Min on 100% O_2:** ____ **mmHg**	**3 Min on 100% O_2:** ____ **mmHg**
4 Min on 100% O_2: ____ **mmHg**	**4 Min on 100% O_2:** ____ **mmHg**	**4 Min on 100% O_2:** ____ **mmHg**
5 Min on 100% O_2: ____ **mmHg**	**5 Min on 100% O_2:** ____ **mmHg**	**5 Min on 100% O_2:** ____ **mmHg**
10 Min on 100% O_2: ____ **mmHg**	**10 Min on 100% O_2:** ____ **mmHg**	**10 Min on 100% O_2:** ____ **mmHg**

RPI= Extremity site divided by reference site on air. **ABI**: __________



On diagram, shade location of wound, cross out amputated extremities. Place an X on each electrode site and label with corresponding site number above.

Interpretation:

Physician Signature: ______________________

Site #________ Room Air ________mmHg

In-Chamber TCOM

Record values every 10 mins up to 200mmHg:

2.0 ATA	________	**mmHg**
2.1 ATA	________	**mmHg**
2.2 ATA	________	**mmHg**
2.3 ATA	________	**mmHg**
2.4 ATA	________	**mmHg**
2.5 ATA	________	**mmHg**

ATA x 14.7-14.7=psig

Revised 9/2015

THE HYPERBARIC MEDICINE SERVICE

TRANSCUTANEOUS OXYGEN SCREENING

Name ______________________ Date ________________

Regular Physician ________________________________

You have just undergone a transcutaneous oxygen study of:

☐ **Both feet**

☐ **Your left foot**

☐ **Your right foot**

This test measures the amount of oxygen present in the skin. This information represents an indirect assessment of the health of both the larger blood vessels in your legs, and the smaller ones in your feet.

It is a screening test, which means that additional tests may be necessary, depending upon the results. The information obtained today should be discussed with your regular doctor, who will be responsible for any decision to proceed with further testing, or related care. We have attached several articles that describe the importance of this test in the evaluation of risks for healing compromise, for the benefit of your doctor. Thank you for stopping by!!

FINDINGS

Both Feet	Left Foot	Right Foot	
☐	☐	☐	**Normal exam ≥40 mmhg** -ƙ *there is presently no evidence of a significant blood flow impairment*
☐	☐	☐	**Borderline exam 30 – 39 mmhg** -ƙ *oxygen levels fall within the borderline –to- normal range, and do not presently appear limb or tissue threatening*
☐	☐	☐	**Abnormal exam <30 mmhg** -ƙ *oxygen levels are below the normal anticipated range, and may complicate the healing of any wound or injury.*

For additional information, please call the Hyperbaric Medicine Service at ________________.

Random Report

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