Simple Algorithm of Arterial Blood Gas Analysis to Ensure Consistent, Correct and Quick Responses!

Introduction

Arterial blood gas (ABG) analysis is a crucial part of diagnosing and managing a patient’s state of oxygenation, ventilation status as well as acid-base balance. The practiceability of this diagnostic tool is dependent on being able to correctly interpret the results. The body operates efficiently within a fairly narrow range of blood pH (acid-base balance). Even relatively small changes can be detrimental to cellular function. Disorders of acid-base balance can create complications in many disease states, and occasionally the abnormality may be so severe so as to become a life-threatening risk factor. A thorough understanding of acid-base balance is mandatory for physicians, intensivists, and anesthesiologists, not exception! We must always interpret them in light of the patient’s history, clinical presentation and laboratory information.

Objectives: ABG is not merely a tracing paper! So many variables right at the tracing paper as well as clinical variables of the patients batch fearfulness among young physicians. So the effort was to make ABG EASY and to develop an algorithm which will conduct navigating diagnosis!


Keywords: Oxygenation; Ventilation; Acid-base; Metabolic; Saturation; Bicarbonate

Basic terminology [6-8]

a) \( P^\text{H} \): signifies free hydrogen ion concentration. \( P^\text{H} \) is inversely related to H\(^+\) ion concentration.
b) Acid: a substance that can donate H\(^+\) ion, i.e. lowers \( P^\text{H} \).
c) Base: a substance that can accept H\(^+\) ion, i.e. raises \( P^\text{H} \).
d) Anion: an ion with negative charge.
e) Cation: an ion with positive charge.
f) Acidemia: blood \( P^\text{H} < 7.35 \) with increased H\(^+\) concentration.
g) Alkalemia: blood \( P^\text{H} > 7.45 \) with decreased H\(^+\) concentration.
h) Acidosis: Abnormal process or disease which reduces \( P^\text{H} \) due to increase in acid or decrease in alkali.
i) Alkalosis: Abnormal process or disease which increases \( P^\text{H} \) due to decrease in acid or increase in alkali.

Requirement of acid-base balance [7,8]

Acid-base balance is important for metabolic activity of the body:
\[
P^\text{H} \text{ of arterial blood} = 7.35 - 7.45.
\]
Alteration of pH value out of the range 7.35-7.45 will have effects on normal cell function.

$\text{P}^\text{H} < 6.8$ or $\text{P}^\text{H} > 8.0$ death occurs.

Changes in excitability of nerve and muscle cells

$\downarrow \text{P}^\text{H} \rightarrow$ depresses the CNS

Can lead to loss of consciousness.

$\uparrow \text{P}^\text{H} \rightarrow$ over-excitability of CNS

Tingling sensations, nervousness, muscle twitches.

Alteration of enzymatic activity:

$\text{P}^\text{H}$ change out of normal range can alter the shape of the enzyme rendering it non-functional.

Alteration of K+ levels

Acid-base state of ECF influence:

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K⁺ distribution in ECF and ICF
Renal excretion of K⁺

Acid-base disturbance or imbalance

I. Acid-base balance: the process maintaining pH value in a normal range

Acid-base disturbance or imbalance

Many conditions can alter body pH:
- Acidic or basic food
- Metabolic intermediate by-products
- Some disease processes

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Acid-base disturbances:

i. Secondary alterations to some diseases or pathologic processes
ii. Can aggravate and complicate the original disease
iii. Concept of acids and bases:
iv. Acids are molecules that can release H⁺ in solution. (H⁺ donors)
v. Bases are molecules that can accept H⁺ or give up OH⁻ in solution. (H⁺ acceptors)
vi. Acids and bases can be:
   a. Strong – dissociate completely in solution
      HCl, NaOH
   b. Weak – dissociate only partially in solution
      Lactic acid, carbonic acid

Regulation of acid-base balance

a. Blood buffering
   React very rapidly (less than a second)
   b. Respiratory regulation
   Reacts rapidly (seconds to minutes)
c. Ion exchange between intracellular and extracellular compartment and intracellular buffering
Reacts slowly (2~4 hours)
d. Renal regulation
Reacts very slowly (12~24 hours)

<table>
<thead>
<tr>
<th>Table 2.5 Hydrogen Ion Concentrations and pH</th>
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<td>Grams of H⁺ per Liter</td>
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- Normal concentration of H⁺ in body fluid is \( 4 \times 10^{-8} \text{mol/L} \).
- \( \text{pH} = -\log [H^+] \)
- Range of pH is from 0 - 14
- Normal pH of blood is 7.35-7.45
Respiratory regulation

The lung regulates the ratio of \([\text{HCO}_3^-]/[\text{H}_2\text{CO}_3]\) to approach 20/1 by controlling the alveolar ventilation and further elimination of \(\text{CO}_2\), so as to maintain constant \(\text{PH}\) value.

Regulation of alveolar ventilation \((V_A)\)

a. \(V_A\) is controlled by respiratory center (at medulla oblongata).

b. Respiratory center senses stimulus coming from:
   - Central chemoreceptor (located at medulla oblongata)
   - Alteration of [H+] in Cerebrospinal fluid
     \(\uparrow\) [H+] in Cerebrospinal fluid \(\rightarrow\) respiratory center exciting \(\rightarrow\) \(\uparrow \ V_A\)
   - Alteration of PaCO\(_2\)
     \(\text{PaCO}_2 > 60\text{mmHg} \rightarrow V_A\) increase 10 times
     \(\text{PaCO}_2 > 80\text{mmHg} \rightarrow\) respiratory center inhibited
     Peripheral chemoreceptor (carotid and aortic body)
   - \(\downarrow\) PaO\(_2\) or \(\uparrow\) PaCO\(_2\) or \(\uparrow\) [H\(^+\)]
     \(\downarrow\) PaO\(_2\) < 60mmHg \(\rightarrow\) respiratory center exciting \(\rightarrow\) \(\uparrow V_A\)
     \(\downarrow\) PaO\(_2\) < 30mmHg \(\rightarrow\) respiratory center inhibited

How does alteration of alveolar ventilation regulate \(\text{PH}\) value?

\(\uparrow\) [H\(^+\)] in Blood \(\rightarrow\) rapidly buffered by buffer system such as \(\text{HCO}_3^-/\text{H}_2\text{CO}_3\rightarrow \downarrow \text{[HCO}_3^-] \) and \(\uparrow \ [\text{H}_2\text{CO}_3] \rightarrow \downarrow \frac{[\text{HCO}_3^-]}{[\text{H}_2\text{CO}_3]}\) tend to decrease, while \(\uparrow\) [H\(^+\)] can stimulate peripheral chemoreceptor \(\rightarrow\) respiratory center exciting \(\rightarrow\) alveolar ventilation \(\rightarrow\) CO\(_2\) elimination \(\rightarrow\) \(\downarrow\) PaCO\(_2\) \(\rightarrow\) \(\downarrow \frac{[\text{HCO}_3^-]}{[\text{H}_2\text{CO}_3]}\) tends to 20/1 \(\rightarrow\) \(\text{PH}\) is maintained.

Renal regulation

The kidney regulates \([\text{HCO}_3^-]\) through changing acid excretion and bicarbonate conservation, so that the ratio of \([\text{HCO}_3^-]/[\text{H}_2\text{CO}_3]\) approach 20/1 and \(\text{PH}\) value is constant.

Bicarbonate conservation

a. Bicarbonate regeneration by distal tubule and collecting duct.
   - Bicarbonate reclamation by proximal tubule.

How does the renal regulation maintain the constant \(\text{PH}\) value?

\(\uparrow\) [H\(^+\)] in Blood \(\rightarrow\) rapidly buffered by buffer system such as \(\text{HCO}_3^-/\text{H}_2\text{CO}_3\rightarrow \downarrow \text{[HCO}_3^-]\) and \(\uparrow \ [\text{H}_2\text{CO}_3] \rightarrow \downarrow \frac{[\text{HCO}_3^-]}{[\text{H}_2\text{CO}_3]}\) tend to decrease, while \(\uparrow\) [H\(^+\)] can stimulate the activity of CA, H\(^-\)ATPase and glutaminase \(\rightarrow\) secretion of H\(^+\) and ammonia, \(\rightarrow\) reabsorption of \(\text{HCO}_3^-\rightarrow \left[\text{HCO}_3^-\right]/\left[\text{H}_2\text{CO}_3\right]\) tends to 20/1 \(\rightarrow\) \(\text{PH}\) is maintained.

Ion exchange between intra- and extracellular compartment & intracellular buffering:

A. Intracellular buffer system
   - Phosphate buffer system \((\text{HPO}_4^{2-}/\text{H}_2\text{PO}_4^-)\)
b. Hemoglobin (Hb/HHb) and oxyhemoglobin buffer system (HbO₂/HHbO₂)

B. Ion exchange between intra- and extracellular compartment
i.e. Extracellular [H⁺] → H⁺ shift into cells and K⁺ shift out of cells
   a. acidosis→ hyperkalemia
   b. alkalosis→ hypokalemia

Base excess & base deficit [9,10]

In human physiology base excess and base deficit refer to an excess or deficit, respectively, in the amount of base present in the blood. The value is usually reported as a concentration in units of mEq/L, with positive numbers indicating an excess of base and negative a deficit. A typical reference range for base excess is −2 to +2 mEq/L. Comparison of the base excess with the reference range assists in determining whether an acid/base disturbance is caused by a respiratory, metabolic, or mixed metabolic/respiratory problem.

The base excess of blood does not truly indicate the base excess of the total extracellular fluid (ECF). Because of different protein content and the absence of hemoglobin, ECF has a different buffering capacity. What’s more, each extracellular fluid (for example CSF vs interstitial fluid) has a different buffer status. The clinical determination of the amount of bicarbonate required for treatment of severe acidosis is usually based on the base excess of the blood. There is an unavoidable inaccuracy, however, due to several factors:

i. The time course of the acidosis makes the blood acid poorly reflect the total body acid burden in many cases.

ii. Depending on the state of hydration, body fluid distribution varies.

Facts about Acid-Base balance…… [13]

… A respiratory component
  … A respiratory acid
  … Moves opposite to the direction of P⁰².

… A metabolic component
  …. It is a base (Metabolic)
  …. Moves in the same direction of P⁰².

Compensation of primary & mixed disorder

Compensation for simple acid-base disturbances always drives the compensating parameter (ie, the PCO₂ or HCO₃⁻) in the same direction as the primary abnormal parameter (ie, the [HCO₃⁻] or PCO₂) & compensation for mixed disorder always drives compensating parameters in the opposite direction as the primary abnormal parameters.

Tips for determining primary and mixed acid base disorder [11,12]

Tip-1: Only a process of acidosis can make the P⁰² acidic and only a process of alkalosis can make P⁰² alkaline

Tip-2: In primary disorder P⁰² 7.35 ─ 7.40 is indicative of primary acidosis, when compensation is complete

Tip-3: In primary disorder P⁰² 7.40 ─ 7.45 is indicative of primary alkalosis, when compensation is complete

Tip-4: Keeps in mind that three states of compensation are possible:
   a) Non-compensation- alteration of only PCO₂ or HCO₃⁻
   b) Partial-compensation- When all three variables like P⁰², PaCO₂ and HCO₃⁻ are abnormal.
   c) Complete-compensation- P⁰² is normal but both PaCO₂ & HCO₃⁻ are abnormal.

Tip-5: Don’t interpret any blood gas data without examining corresponding serum electrolytes.

Tip-6: Truly normal P⁰² with distinctly abnormal HCO₃⁻ and PaCO₂ invariably suggests two or more disorders.

Tip-7: Whenever the PCO₂ and [HCO₃⁻] are abnormal in opposite directions, ie, one above normal while the other is reduced, a mixed respiratory and metabolic acid-base disorder exists.
Moves in same direction

... Primary disorder

... Moves in opposite direction

... Mixed disorder

Description of superscripts inside algorithm box [15-29]

a. Increase or decrease of $P^H$ in relation with $HCO_3^-$ indicate metabolic disorder

b. Increase or decrease of $P^H$ in relation with $PCO_2$ indicate respiratory disorder

c. Step to look at compensation, noncompensation means alteration of only $PCO_2$ or $HCO_3^-$

d. Partial compensation means $P^H$, $PCO_2$ and $HCO_3^-$ all variables are abnormal

e. Full compensation means only $P^H$ is normal but $PCO_2$ and $HCO_3^-$ are abnormal

f. Anion Gap (AG) = $Na^+ -(Cl^- + HCO_3^-)$, it represents unmeasured anions in the plasma which primarily includes Sulphate, Organic acids, Albumin and Phosphate (SOAP). The normal value of AG is 12 ± 4, an increase AG almost always indicates metabolic acidosis

g. HAGMA (High Anion Gap Metabolic Acidosis)- Increase anion gap means an acid has been added to the blood, causes are KULT means Ketoacidosis, Uraemia, Lactic acidosis, Toxins

h. NAGMA (Normal Anion Gap Metabolic Acidosis)- when $HCO_3^-$ is lost to maintain electroneutrality $Cl^-$ is conserved by Kidney's, so anion gap is normal, causes are DURHAM means Diarrhoea, Uretersigmoid fistula, RTA, hyperalimentation, Acetazolamide, Misc

i. Delta Gap=ΔAG/ΔHCO_3^-

Delta ratio is a formula that can be used to assess elevated anion gap metabolic acidosis and to evaluate whether mixed acid base disorder is present.

In High anion gap metabolic acidosis (HAGMA) Delta ratio will be 1-2

If the ratio is greater than 2 in a HAGMA it is due to concurrent metabolic alkalosis.

In Nonanion gap metabolic acidosis (NAGMA) delta ratio will be ≈ 0.4

If the ratio is between 0.4-1 then it is due to Mixed (HAGMA+NAGMA) disorser

Bedside Rules for Assessment of Compensation [14]

Rule 1: The 1 for 10 Rule for Acute Respiratory Acidosis

The $[HCO_3^-]$ will increase by 1 mmol/l for every 10 mmHg elevation in $PCO_2$ above 40 mmHg.

Expected $[HCO_3^-] = 24 + ((Actual PCO_2 - 40) / 10)$

Rule 2: The 4 for 10 Rule for Chronic Respiratory Acidosis

The $[HCO_3^-]$ will increase by 4 mmol/l for every 10 mmHg elevation in $PCO_2$ above 40mmHg.

Expected $[HCO_3^-] = 24 + 4 ((Actual PCO_2 - 40) / 10)$

Rule 3: The 2 for 10 Rule for Acute Respiratory Alkalosis

The $[HCO_3^-]$ will decrease by 2 mmol/l for every 10 mmHg decrease in $PCO_2$ below 40 mmHg.

Expected $[HCO_3^-] = 24 - 2 ((40 - Actual pCO_2) / 10)$ (range: +/- 2)

Rule 4: The 5 for 10 Rule for a Chronic Respiratory Alkalosis

The $[HCO_3^-]$ will decrease by 5 mmol/l for every 10 mmHg decrease in $PCO_2$ below 40 mmHg.

Expected $[HCO_3^-] = 24 - 5 ((40 - Actual pCO_2) / 10)$ (range: +/- 2)

Rule 5: The One & a Half plus 8 Rule - for a Metabolic Acidosis

The expected $PCO_2$ (in mmHg) is calculated from the following formula:

Expected $PCO_2 = 1.5 \times [HCO_3^-] + 8$ (range: +/- 2)

Rule 6: The Point Seven plus Twenty Rule - for a Metabolic Alkalosis

The expected $PCO_2$ (in mmHg) is calculated from the following formula:

Expected $PCO_2 = 0.7 \times [HCO_3^-] + 20$ (range: +/- 5)

Conclusion [30]

The Analysis of arterial blood gas values have significant role to identify the causes of acid base and oxygenation disturbances. For accuracy arterial blood gases should never be interpreted by themselves, it must always interpret them in light of the patient’s history and clinical presentation. It also has great impact on bedside patient management as well.
Algorithm for interpreting arterial blood gas analysis: (Annexure-1)
References

30. www.carta.ca/contentFiles/file/pandemic.../ABGinterpretation.doc