



Diagnos^tics

Nov./Dec. '00

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Notes from the Chair

by Catherine M. Foss, BS, RRT, RPFT

Season's Greetings! As I write this column in mid-October, I have just returned from the AARC International Congress in Cincinnati. The Congress included some great diagnostics sessions, as well as a follow up business meeting on the last day. For those of you who were unable to attend, the minutes of the business meeting are featured in this *Bulletin*.

The last few months have been a time of personal adventure and renewal. I would like to thank those of you who voted in the AARC election for section chair. I feel fortunate to have won the election and am looking forward to my continued service as your chair. This fall, I also relocated to Raleigh, NC, and am now working at Duke Hospital. If you tried to send me an email in September or October and did not receive a response, please resend your message to my new address: foss0005@mc.duke.edu.

As we prepare to enter the new year, I would like to ask that each of you place a new emphasis on your professional growth and development. There are many opportunities for you to share your knowledge and assist peers in the diagnostic respiratory field. I have committed myself to serving as your chair-elect and chair over the next four years. But I need feedback from all of you regarding the needs of our section and the directions you believe it should take. I also need your assistance with section activities. Opportunities for involvement include:

- Serve as editor of the *Bulletin*.
- Write an article for the *Bulletin*. This is a great way to share your experiences or

thoughts with your peers.

- Submit proposals for topics at the 2001 AARC International Congress in San Antonio, TX. You can email me with your ideas, post them on the section list-serve, or send your thoughts in proposal form directly to the AARC. The proposal forms are located on the AARC web site. Log onto www.aarc.org, then click on the area called "Request for Proposals" and follow the directions given there. The deadline for submitting topics is December 29.
- Serve as our Internet coordinator. This individual is responsible for suggesting links to place on the Diagnostic Section area of the AARC web site and either responding to diagnostic issues posted on the AARC HelpLine or referring such issues to the chair for attention.
- Serve on the section's Nominations Committee.
- Serve on the section's Specialty Practitioner of the Year Committee.

Finally, I'd like to make special mention of several members who gave many hours of their valuable time to assist the section over the past year: Carl Mottram, past chair, for mentoring and guidance; Susan Blonshine and Steve Nelson, for serving as our internet coordinators; and Pauline Wulbrecht and Joyce Canterbury, who worked diligently as our *Bulletin* editors. My sincere appreciation to all of you and everyone else who helped make 2000 another successful year for our section. ■

Diagnostic Section Business Meeting Minutes

by Catherine M. Foss, BS, RRT, RPFT

The section business meeting was convened at the AARC International Congress on Tuesday, October 10. The following topics were discussed.

• Communications

The *Diagnos^tics Bulletin*, which is published six times a year, is looking for peer input. Featured topics include cardiac, multi-disciplinary, pulmonary physiology, pulmonary function, bron-

choscopy, polysomnography and sleep issues, and blood gases.

• Networking

The AARC website, www.aarc.org, features a "members only" area for section members, which can be accessed by clicking on the "Community" heading

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on the main page. Section members can sign up for the Diagnostics listserve at no additional cost. Members are also encouraged to share their favorite Internet sites with their peers. Email your sites to Cathy Foss or simply post them on the listserve and we'll add them to the list. In addition to these network-

Diagnosics Bulletin

is published by the
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for Respiratory Care**
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ing opportunities, section members may access a Resource Directory consisting of peers who have volunteered to answer questions in their area of expertise.

• Diagnostic Section's future

Recruitment of new members to both the AARC and the Diagnostic Section is vitally important. Bill Dubbs, AARC associate executive director, spoke to the group on this matter, reinforcing the opportunity that exists for our section to earn a seat on the AARC Board of Directors. We must have at least 1000 members to acquire a seat, and thus a say in the future and direction of the AARC. We currently are just above 800 members.

• Section Opportunities

Members are encouraged to get involved in the section by serving as: Internet coordinator, *Bulletin* editor, *Bulletin* author, coordinator and/or committee member for Specialty Practitioner of the Year and Nominations Committees.

• Specialty Practitioner of the Year (SPOY)

Nomination forms for this structured process will be available mid-year. Congratulations to Pauline Wulbrecht, our 2000 SPOY winner!

• Clinical Practice Guidelines (CPGs)

Carl Mottram, the Diagnostic Group CPG chair, spoke briefly on the just-completed revisions to the CPGs. Publication is expected in January. Current diagnostic-related AARC CPGs, which can be found online at www.rcjournal.com, include the following:

- Spirometry
- Diffusing Capacity
- Static Lung Volumes
- Body Plethysmography
- Arterial Blood Gas Puncture
- Arterial Blood Gas Analysis
- Pulse Oximetry
- Bronchoscopy
- Infant Testing
- Metabolic Testing
- Polysomnography
- Cardiopulmonary Exercise Testing

• American Thoracic Society (ATS) Issues

The ATS will publish a Six Minute Walk Statement in the first quarter of 2001. Carl Mottram is an Ad Hoc committee member. Dr. Paul Enright is chairing this group.

• National Association of Medical Directors of Respiratory Care (NAMDRC)

The NAMDRC newsletter, *Washington Watchline*, recently focused on new edits from the Health Care Financing Administration concerning coding issues.

• Educational Materials

AARC *Individual Independent Study Packages* (IIPSS) are available on a variety of topics:

- Static lung volumes
- Spirometry
- Whole body plethysmography
- Diffusing capacity
- Peak flow

American Thoracic Society Pulmonary Function Procedure Manual is available online at www.thoracic.org or by calling (212) 315-8700.

Alpha-1 Educational Brochure: This pulmonary function testing patient information booklet can help other allied health practitioners obtain a basic knowledge of pulmonary function testing. It is written at an eighth grade reading level. The cost is \$.30/each if ordering more than 10 brochures. Order online at <http://alpha1.org/market1.htm> or call (800) 521-3025.

Uniform Reporting Manual Update for Diagnostics, an AARC publication, is available for purchase from the AARC.

• National Committee for Clinical Laboratory Standards

Susan Blonshine gave an update on the HS-3 and HS-4 standards. Comments are being collected until January 1 for the document on Quality Systems in Respiratory Care. This is a new combination document with everything for pH and blood gas analysis. Section members are encouraged to read the document (located online at www.nccls.org) and provide comments.

• Research and Outcomes Studies

Attendees were encouraged to produce abstracts for the 2001 International Congress in San Antonio. Updates on the NETT and ATRA emphysema trials were presented.

• Government Issues

CDC committee members Carl Mottram and Susan Blonshine gave updates on their attendance at an Ad Hoc meeting, which also included representatives from the FDA and HCFA, and scientists. "Other breath tests," such as hydrogen, urea, and GI tests, were discussed. Pulmonary testing and nitric oxide analysis were also covered. The Ambulatory Procedure Classifications became effective August 1. A discussion ensued concerning the impact on outpatient coding and reimbursement. Please email Cathy Foss at foss0005@mc.duke.edu with your personal reflection of the impact of this new regulation on your department.

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• **2001 Program**

Practitioners, we need your input!
Program proposals are due December 29 for the International Congress in San

Antonio, TX, Dec 1-4, 2001. You may fill out a proposal form available online at the AARC website or send your ideas to Cathy Foss via email. Practitioners in the audience suggested the following:
More on polysomnography

Metabolic measurement studies and their use in pregnancy
Using protocols in diagnostics
Having an interactive session for a diagnostic topic such as PFT or exercise interpretation. ■

Specialty Practitioner of the Year: Pauline Wulbrecht, RPFT



Two years ago, Pauline Wulbrecht, RPFT, clinical manager of pulmonary/dermatology and podiatry services at Scott & White Hospital in Temple, TX, was given the opportunity of a lifetime when she was asked to play a major role in relocating her hospital's pulmonary function laboratory to new space within the institution. Over the next several months, she helped to redesign the layout of the lab, developing what she calls a "model of excellence for pulmonary diagnostic services." With multiple testing rooms that allow for the performance of all modes of pulmonary function testing, the

new lab has a friendlier feel for patients, and services are now delivered in the most efficient manner possible.

At the same time, she has aggressively supported the standardization of testing throughout both the hospital itself and the regional clinics located within the Scott & White system, ensuring that all spirometers and staff follow American Thoracic Society standards. "Clinical decisions are made based on test results," says Pauline. "Patients should not have to have tests repeated, receive inappropriate medical management, be refused chemotherapy treatment, or be refused admission to one of the military academies because their test results were of poor technical quality but released as valid

anyway."

Pauline, who has been a member of the AARC and the Diagnostics Section since 1992 and has served as co-editor of the *Bulletin* for the past two years, credits membership in the section with increasing her ability to bring such state-of-the-art practices to patients at her hospital. "Our knowledge grows by talking to others about like experiences or new things we may want to try. We encourage our patients to be in support groups to help them through various situations — this is no different. If we are to have guidelines that apply to all diagnostic practitioners, we must have a place where we can all come together to have input." ■

The Safety of Brachial Artery Puncture for Arterial Blood Sampling

by Gyman C. Okeson, MD, FCCP; and Pauline H. Wulbrecht, RPFT

Editor's Note: The following article, which was published in CHEST in 1998 (114:748-751) and is reprinted here with permission, grew out of concerns by some medical staff about having our pulmonary lab at Scott and White Hospital in Temple, TX, perform brachial punctures. A literature search showed a dismal lack of information; in fact most "horror" stories about complications of brachial puncture appeared to be hearsay or not well documented. In response, we decided it was time to speak up about our experiences, and a review of all punctures was initiated. As this study shows, well-trained staff can do brachial artery punctures safely. My medical director and I encourage all respiratory therapists to speak up when it comes to the appropriate procedure for radial or brachial arterial puncture. RTs, you are the experts! — Pauline Wulbrecht

Obtaining arterial blood for blood gas analysis has become a routine procedure in most hospitals and many outpatient clinics. Thirty years ago, arterial punctures were primarily performed by physicians because of the potential for serious complications. Today, with improved training and equipment, it is commonly performed by nurses, laboratory technicians, and respiratory therapists, without physician assistance.

Arterial blood samples from the upper extremities are usually performed using the radial artery, even though radial artery punctures are often technically more difficult to perform and may cause the patient more discomfort.¹ The radial artery is preferred because of the common belief that brachial artery punctures are significantly more dangerous for the patient.

In our pulmonary laboratory, brachial artery puncture has been the preferred method for obtaining arterial blood for blood gas analysis for >30 years. This route was preferred because of our clinical impression that it was safe, caused less discomfort, and was technically easier for the technician. We found surprisingly little information about the incidence of complications for brachial or

radial artery sampling in the medical literature. Most published reports were anecdotal, detailing complications without reference to the rate of occurrence. This prompted us to report the incidence of complications in 6,185 consecutive brachial artery punctures performed for blood gas analysis in our laboratory between 1992 and 1996.

Materials and methods

We prospectively recorded the following information on all patients having arterial blood gases drawn: (1) the arm from which blood was obtained; (2) the number of sticks required to obtain the sample; and (3) the presence or absence of any complication at the time of the procedure. Each time a complication was noted, the medical record was reviewed 48 h and 2 months later to ascertain the seriousness, duration, and outcome of the complication.

A registered or certified pulmonary function technician performed all brachial artery punctures. Our technicians are trained by the more experienced technicians in the

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department to do both brachial and radial artery punctures and follow established standard protocols.² An important part of their training involves learning to assess the patient’s condition, confirm that the patient is receiving the ordered fraction of inspired oxygen, assure appropriate sample handling, and note what respiratory treatments are in progress at that time. Their training has also included identifying contraindications, hazards, complications, and limitations associated with the procedure, as well as the proper method for applying pressure to the artery after needle withdrawal.^{3,4} Technicians may not perform arterial punctures without supervision until their trainer is satisfied they are competent to perform the procedure.

In all subjects, the arterial pulsation was identified and the antecubital fossa was cleaned with an alcohol pledget. No local anesthesia was used. The brachial artery was entered percutaneously using a 20-gauge needle with attached syringe. If the patient experienced pain or if blood could not be obtained, the needle would then be withdrawn and the procedure was moved to the opposite arm. After the sample was obtained, manual pressure was applied to the artery for a minimum of 3 min, but often as long as 10 min if the patient was receiving anticoagulation therapy. After the application of pressure, the site was carefully inspected for any sign of swelling or discoloration. If either was noted, additional pressure was applied and the attending physician was notified so he or she could inspect the site later. If the patient had had a recent brachial artery puncture, the opposite arm was preferentially used. Brachial artery punctures were never performed through an existing hematoma, antecubital scar, or open wound. None of these patients had arterial cannulations or intra-arterial injections.

Results

During the period of January 1992 through January 1996, a total of 6,185 brachial arterial punctures were performed. The subjects were all adults. The age range was 18 to 94 years. Sixty-three percent of brachial artery sticks were performed on patients in their sixth and seventh decades of life, 19% in their fourth and fifth decades, 14% in their eighth and ninth decades, and 4% in patients <30 years of age. Forty-nine percent were female and 51% were male. Seventy-five percent of the arterial sticks were performed on outpatients in the medical clinic, 21% were performed on patients in general hospital wards, and 4% were performed on patients hospitalized in the ICU. Only 155 (2.5%) required more than one stick to obtain the arterial blood sample. One

hundred twenty-seven (2.0%) complications were recorded. These occurred in a random fashion, with none arising in patients who required multiple sticks. The complications were of two types. The most common complication recorded was that of extremity pain or paresthesias, which was noted in 123 instances (group 1). Only four punctures resulted in hematoma formation (group 2).

A little more than half of group 1 patients (66 subjects) complained of pain at the time of the arterial stick. Of these, one fourth (16 subjects) complained of temporary diffuse pain in the extremity, one half (33 subjects) complained of localized discomfort at the needle site, and one fourth (17 subjects) experienced a shock-like pain, suggesting that the median nerve had been touched by the needle. Only one patient had discomfort that lasted >48 h. A neurologist saw her 10 days after the procedure. At that time, there was pain without objective ischemic or neuropathic change. The symptoms resolved spontaneously, without treatment, sometime prior to a second visit at 2 months. Fifty-seven patients noted no discomfort at the time of the procedure, but developed hand pain or acroparesthesia in the fingers within 24 h following the procedure. Only one had persistent symptoms. She noted the onset of pain and paresthesias in her thumb 4 days after the procedure. She was evaluated by a neurologist, who found no objective abnormality. The pain subsided within 4 months with the use of oral ibuprofen.

Only four patients had identifiable antecubital hematomas after the procedure. None of these patients were receiving anticoagulants at the time of the arterial stick. Two of these were clinic patients and two were hospitalized in general medical wards. None were in the ICU. None of the hematomas resulted in subsequent ischemia or other serious complication and all resolved spontaneously. The incidence of the complications as a percent of the entire group is listed in Table 1.

Discussion

This prospective study involving 6,185 brachial artery punctures for arterial blood gas analysis documents that this is an acceptably safe procedure with a low incidence of complications when performed by properly trained personnel. We considered all of our complications to be minor, since none had any lasting or serious consequence for the patient. In our opinion, brachial artery punctures are technically easier to perform and generally associated with less discomfort than radial artery punctures. Our results were similar to a 1973 report by Felkner,² who found 2,500 arterial sticks without serious complication. Unfortunately, Felkner did not categorize complications by puncture site. Petty et al⁵ reported in 1966 on the simplicity and safety in 475 arterial punctures with only minor hematoma formation.

The medical literature has been almost totally silent on this subject over the past 15 years. We found no reports that documented the incidence of complications. Most reports involved anecdotal accounts of cases that resulted in complications that, when taken collectively, give the impression that brachial artery punctures are fraught with frequent and serious complications.

McCready et al⁶ reported one case of limb ischemia noted 6 h after a brachial artery stick. The patient was being treated for an abdominal catastrophe and was in postoperative shock.⁶ The ischemia was complicated by the fact that IV fluid had infiltrated into the hand. There was no mention of what medication(s) might have been in the IV fluid. Treatment consisted of IV heparin and a stellate ganglion block. Eighteen hours later, the extremity gradually improved. Subsequent surgical exploration of the arm showed edema of the tissues without other abnormalities. They concluded that the cause of this patient’s limb ischemia was unclear. In 1976, Neviasser et al⁷ reported the complications of brachial and femoral artery punctures in 13 patients who were receiving

Table 1—Brachial Artery Punctures: Incidence of Complications

Punctures/Complications	No. (%)
Arterial punctures	6,185
Total complications	127 (2.0)
Immediate pain/paresthesias	66 (1.1)
Delayed pain/paresthesias	57 (0.9)
Hematoma formation	4 (0.06)

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heparin therapy. The complication rate was not reported even though complications were categorized by puncture site. Two patients had hematomas after brachial artery sticks. They reported large hematomas that were associated with the development of median neuropathies. They also reported the development of infected hematomas after repeated arterial punctures performed through the existing antecubital hematomas. This report underscores the importance of proper attention to the arterial puncture site during and immediately after the procedure and the importance of not repeating the procedure in an extremity after a complication had already arisen. Both of the reported cases required incision and drainage of the affected arm and, in one case, required skin grafting. They reported two median nerve neuropathies, one with incomplete recovery of motor function 1 year later, and the second recovering after decompression and neurolysis. They also described seven patients presenting with ischemic change secondary to bruising and tenseness of the flexor compartment of the forearm. At surgical decompression, they noted ecchymoses and swelling that extended from the antecubital fossa into the carpal canal.

An extensive 1967 study by Mortensen⁸ of 3,193 arterial needle punctures, cannulations, and cut-downs reported on 66 major complications and 321 minor complications. The study included all arterial punctures for any reason, including arteriography and cardiopulmonary bypass. One thousand four hundred sixty-six percutaneous artery punctures had a major complication rate of 1.3% and minor a complication rate of 10%. The remainder of the arterial punctures involved arterial catheterization by the Seldinger technique (719) and cutdown arteriotomy with repair (1,008). The Seldinger technique, which is no longer in use, was associated with an increased rate of complications (4.4% and 14.3% respectively). Of the percutaneous needle punctures, there were only 34 brachial artery punctures listed, but they reported an 8.9% rate of major and a 33% rate of minor complications. Overall, they listed the factors predisposing to complications as follows: (1) an age of <10 years; (2) the presence of arteriosclerotic vascular disease or hypertension; and (3) concurrent anti-

coagulation. These authors made a plea for objective studies of complication rates, since anecdotal recollection is frequently faulty.

The most recent report that we found was a 1989 case report by Berger.⁹ This involved a patient who had developed a median neuropathy following brachial artery puncture.⁹ This report lacked specific information about the resulting median neuropathy. He reported immediate pain of neuropathic type when the nerve was struck by the needle. The pain resisted all treatment modalities for >1 year and apparently resulted in permanent sequelae. Unfortunately, the article specifies that there was “pain at the site of the injection,” but fails to indicate what, if anything, was injected.

Ward and Green¹⁰ reported on 588 patients who underwent 1,360 arterial punctures of various kinds. They reported only one potential complication of a brachial artery puncture. The complication occurred in a patient with a cannulated brachial artery who had had a right middle lobectomy, but who also had developed postoperative GI bleeding and shock. The extremity where the arterial puncture occurred became pulseless. After hydration and reestablishment of BP, the pulse returned. Again, there was no mention of the number of procedures by puncture site. They concluded that complications increased when radiographic dyes or drugs were injected into the arteries, there was significant arteriosclerotic disease, or there was long-term catheterization of the artery.

We believe that our results show that brachial artery puncture for arterial blood gas analysis is an acceptably safe procedure in adults when performed by trained, experienced personnel following established guidelines. We believe that the immediate withdrawal of the needle at the first perception of neuropathic pain is important, and that further arterial punctures should not be done in that extremity. It is also important to apply adequate pressure over the puncture site for at least 3 min to prevent hematoma formation. The puncture site should be inspected carefully for signs of hematoma formation after pressure is discontinued so that pressure can be reinstated if bleeding is suspected.

We would certainly agree that anticoagulation would increase the potential risk of hematoma formation and would require pressure to be applied for a much longer time than usual. Although we did not record the

number of arterial punctures done on patients who were receiving anticoagulant therapy, none of the patients who developed hematomas had been receiving anticoagulants. Most of our patients were in the age group in which atherosclerosis and hypertension are common. If these conditions contribute to the risk of complications, as others have suggested, the influence must be very small. None of our patients had received intra-arterial injections. It is conceivable that this could increase the complication rate, depending on the nature of the material injected. The literature would suggest that complications may be more severe in patients who are in cardiovascular shock at the time arterial blood is obtained.

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FYI . . .

New test classifies bacteria in CF lungs

A laboratory test developed by University of Iowa researchers indicates that the lungs of cystic fibrosis patients are infected primar-

ily with bacterial biofilms, organized communities of bacterial cells that are extremely resistant to antibiotic treatment. The bacterial cells produce signaling molecules that allow the cells to communicate with each

other. At a critical cell density, these accumulated signals trigger the expression of a specific set of genes, which results in the

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formation of the biofilm. By growing as a biofilm, bacteria can survive and thrive in hostile environments.

Although the *P. aeruginosa* isolated from the lungs of CF patients looks like a biofilm and acts like a biofilm, until now there has not been an objective test available to confirm that it is a biofilm. In this study, researchers developed a sensitive new test which shows that *Pseudomonas* from CF lungs produce the telltale, quorum-sensing molecules that are the signals for biofilm formation. They believe the most exciting implication of this result is that it could be used to develop automated processes to test thousands of compounds for the ability to disrupt biofilm formation. Says lead study author, E. Peter Greenberg, PhD, "I think this will attract interest from industry where they are very interested in being able to use high throughput, automated processes to rapidly identify compounds that inhibit biofilm formation." (Nature, 10/12/00)

Lung function data on Chinese children and adolescents

Researchers who gathered lung function data on normal Hong Kong-born Chinese children and adolescents between the ages of 7 and 19 found that flow volume capacity (FVC) in boys was 8% to 10% lower than figures for white youngsters. Study results also demonstrated a significant increase in forced expiratory volume in 1 second, as well as improved FVC, when the data were com-

pared to 1985 data for Chinese youngsters. According to the head investigator, the most important characteristic predicting lung function values was height; neither age nor weight added accuracy to the results. (American Journal of Respiratory and Critical Care Medicine, 8/00)

Feeling sleepy isn't only criteria for sleep testing

A new study from researchers at the University of Michigan demonstrates that patients with undiagnosed sleep apnea don't always describe their symptoms using the term "sleepiness," thus making it more likely their condition will be misdiagnosed. The study, which was based on a review of survey answers and sleep test results from 190 people who had been referred by their regular physicians for sleep studies, points out how important it is for physicians to listen carefully to how patients describe their problems.

Since the subjects or their physicians suspected a sleep disorder, the individuals in the study don't represent the general population. But investigators believe the results from their sleep tests and their answers to questions about how they felt still yield surprising trends that may be important to both doctors and the many Americans who have yet to seek help for problems with getting a good night's sleep.

In all, 73% of the study's subjects said they suffered from sleepiness, fatigue, tiredness, or lack of energy often or almost all the time. But when the four descriptive terms were compared independently, less than half

the patients reported feeling sleepy often or always, while 62% said they lacked energy often or always, 57% reported problems with fatigue, and 6% said they felt tired. Women were more likely to describe such symptoms.

Asked which of the symptoms was most significant to them, more patients chose "lack of energy" than any other problem, and almost twice as many chose it than "sleepiness." When asked which symptom most kept them from accomplishing what they wanted to do during the day, 44% percent said lack of energy, while only 16% said sleepiness.

Women in the study reported all four symptoms more often than did men. They were four times as likely to say they had a lack of energy and three times as likely to state they felt tired during the day. Only when told they had to choose one of the symptoms did the men show similar rates of complaint as women. Researchers theorize that men may be culturally less willing to admit to any of the problems asked about in the survey, although they note that there could be some neurophysiological differences in the way men and women perceive the effects of poor sleep.

All the subjects in the study came to the sleep lab to have a nighttime sleep test, followed by a daytime exam called a Multiple Sleep Latency Test that measures how quickly a person starts napping in a dark room. In the overnight tests, electrodes recorded the subjects' sleep stages, a blood oxygen-level sensor was used, and monitors kept close track of their breathing patterns. (CHEST, 8/00) ■

AARC Wants to Know Your Top Five Areas of Concern

The AARC is currently seeking input from section members regarding the top five areas of concern unique to our specialty area. Please mail, email, or fax your top five concerns

related specifically to the specialty (not to the AARC or the practice of respiratory care in general) to: Kelli Hagen, 11030 Ables Lane, Dallas, TX 75229, email: hagen@aarc.org,

FAX (972) 484-2720 or (972) 484-6010. The Association will utilize our input in determining priorities for the coming year. ■

JCAHO Site Visit Reports

As of the end of October, the section had received the following response to its request for information about JCAHO site visits:

Facility: Alamance Regional Medical Center
Contact: Karen Bartels, bartkare@amc.com
Inspection Date: 8/3/00

Score: 98% hospital wide; no deficiencies noted in cardiopulmonary blood gas lab

1. What was the surveyors' focus during your last site visit?

Proficiency, staff competencies, policy and

procedures, performance improvement, performance evaluations.

2. What areas were cited as being exemplary?

The IL Impact Data Management System.

3. What suggestions were made by the surveyors?

Make sure therapists document QC reruns when done as a corrective action.

4. What changes have you made to improve compliance with the guidelines?

None noted

Additional comments: Surveyor checked every employee folder for valid state licensure verification.

If you would like to share your site visit experience with fellow section members, please fill out the following form and fax it to the AARC or post your comments on the Management Section listserv on AARC Online (www.aarc.org). ■

JCAHO Accreditation Report

The AARC is currently seeking information on JCAHO accreditation site visits. Please use the following form to share information from your latest site visit with your colleagues in the Association. The information will be posted immediately on the AARC web site at http://www.aarc.org/members_area/resources/jcaho.html and will also be featured in the *Bulletin*.

Accreditation visit you are reporting (choose one):

- Home Care
- Hospital
- Long Term Care
- Pathology & Clinical Laboratory Services

Inspection Date: _____

Facility Name: _____

Contact: _____
(Please provide name and email address.)

1. What was the surveyors' focus during your site visit? _____

2. What areas were cited as being exemplary? _____

3. What suggestions were made by the surveyors? _____

4. What changes have you made to improve compliance with the guidelines? _____

Additional comments:
Mail or fax your form to:
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