Normal jugular bulb oxygen saturation

A Chieregato, F Calzolari, G Trasforini, L Targa, N Latronico

Background: Normal values of the jugular bulb oxygen saturation were obtained in 1942 and in 1963. Correct catheter positioning was not confirmed radiologically.

Methods: Oxygen saturation in the jugular bulb (SjO2), inferior petrosal sinuses (SipsO2), and internal jugular vein was bilaterally measured in 12 patients with Cushings syndrome who were undergoing selective bilateral catheterisation of the inferior petrosal sinuses. In addition, data from the two old series were reanalysed for comparison.

Results: SjO2 values [44.7%] were significantly lower than in the two other series, particularly concerning the normal lower limit [54.6% and 55.0% respectively]. Comparative analysis suggests that contamination with the extracerebral blood of the facial veins and inferior petrosal sinuses was responsible for falsely high SjO2 values in the two old series.

Conclusions: The normal lower SjO2 limit is lower than previously recognised. This may have practical implications for treating severe head trauma patients.

Materials and Methods

The study was approved by the local review board, and written consent was obtained by the patients. The study was carried out in 12 patients (nine females; median age 39 years, range 25–72) with Cushing’s syndrome, whose aetiology had to be defined. Selective bilateral venous sampling in the inferior petrosal sinuses was necessary to distinguish those individuals with microadenoma of the pituitary from some paraneoplastic tumours (for example, carcinoids or phaeochromocytoma) that ectopically produce corticotrophin releasing hormone (CRH) or adrenocorticotrophin hormone (ACTH). We took advantage of this procedure, which was done using a digital subtraction angiography system, to obtain multiple bilateral samples from: (1) internal jugular veins at the level of the 5th cervical vertebra (midlevel) (SmidO2); (2) inferior petrosal sinuses (SipsO2); and (3) dome of internal jugular vein bulbs (SjO2). Correct position of the tip of the catheter was meticulously checked under direct angiographic observation with contrast medium injection. Blood was withdrawn slowly (1 ml per minute) and venous blood was analysed for oxygen saturation with a co-oximeter (IL 482, CO-Oximeter, Instrumentation Laboratory, Milan, Italy).

Patients were excluded if they had abnormal arterial oxygen saturation (<97% in room air), anaemia of recent onset (Hb less than 100 g/l in the past 10 days), or haemodynamic instability. Chronic arterial hypertension is associated with an adaptation of CBF, and metabolic coupling is ultimately affected only by severe involvement of the cerebral vascular circulation. Therefore, stable hypertension was not an exclusion criterion. Conversely, patients with hypertension of recent onset or with poorly controlled hypertension were excluded. Patients were also excluded if they had evidence of acute or chronic diseases affecting the central nervous system (CNS) other than microadenoma of the pituitary, or if they had hyperventilation (more than 25 breaths per minute for at least one minute) during the procedure.

Pain and agitation were carefully avoided because they could induce ACTH secretion and cerebral metabolic rate of oxygen (CMRO2)/CBF changes, both of which were undesirable. The procedure was carried out in a noise-free environment, and accurate local anaesthesia was performed before venous cannulation. Arterial blood pressure was measured at five minute intervals by an automated device with cuff inflation. Arterial oxygen saturation (SaO2) was continuously monitored using a pulse oximeter.

Statistical analysis

SjO2 values are presented as mean, upper (mean plus 2 standard deviations (SD)), and lower (mean minus 2 SD) limit. Precision of each point estimate was evaluated by 95% confidence intervals (95% CI). Comparison of the venous oxygen saturation in the jugular bulbs, inferior petrosal sinuses, and midlevel jugular veins was done using analysis of variance (ANOVA).

SjO2 values from this series were compared to those from the two historical series by Gibbs and colleagues (50 healthy individuals with microadenoma of the pituitary from some paraneoplastic tumours).

Abbreviations: ACTH, adrenocorticotrophin hormone; ANOVA, analysis of variance; CBF, cerebral blood flow; CMRO2, cerebral metabolic rate of oxygen; CNS, central nervous system; CRH, corticotrophin releasing hormone; SjO2, jugular bulb oxygen saturation; SipsO2, inferior petrosal sinus oxygen saturation.
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**RESULTS**

SaO₂ and arterial blood pressure remained stable during the procedure. In two patients simultaneous catheterisation of jugular bulbs was not possible because of severe ear pain, in one the procedure was interrupted due to a contrast medium allergy, and in one the procedure was interrupted due to a contrast medium allergy. Second, blood samples in our study were without extracerebral blood contamination from the facial veins, while in previous studies the jugular desaturation was simply defined as jugular desaturation—that is, situations of critical inadequacy of CBF to CMRO₂, “from norms defined by Gibbs and coworkers,” and have been proven in a single study to independently affect the outcome of severe head trauma.

Differences between right and left SjO₂ in simultaneous samples were not statistically significant, neither in the present series (t = 0.1978, two tailed p = 0.8481) nor in the Gibbs series (t = -0.1464, two tailed p = 0.8846); however, limits of agreement were wider in the latter. Results, expressed as mean difference (95% CI), and upper (95% CI) and lower (95% CI) limits of agreement were as follows: present study: 0.2% (-1.2 to 1.7); 3.7% (1.2 to 6.3); -3.3% (-5.8 to -0.7); Gibbs: -0.1% (-1.3 to 1.1); 6.5% (4.4 to 8.6); -6.7% (-8.8 to -4.6).

**DISCUSSION**

We found significantly lower SjO₂ values in this series (44.7%) than reported in two old series (54.6%, 55.0%), the only ones in which SjO₂ was measured in normal volunteers. The difference was not accounted for by the fact that patients in the present series had Cushing’s syndrome. In fact, all patients had a syndrome of recent onset, whose pathogenesis, whether due to microadenoma of the pituitary or paraceloid tumours, had yet to be defined. In addition, patients with severe unstable hypertension, in whom uncoupling of CBF and CMRO₂ may occur, were excluded.

Three facts are relevant to explain our results. First, we used a digital angiography system and vascular catheters were exactly positioned in the dome of the jugular bulb. In the Gibbs and Datsur series the catheter positioning in the jugular bulb was blind, and cervical x ray confirmation of the final catheter position was not performed. Therefore, extracerebral blood contamination from the facial veins, and as shown in this study, from the inferior petrosal sinuses may have occurred in some patients. Our results support this hypothesis showing that the SjO₂ values in the old series were intermediate between SjO₂ and SipsO₂–SmidjO₂, extracerebral) in the present series. Second, blood samples in our study were withdrawn slowly, a factor that has been shown to avoid extracerebral blood contamination, provided that the catheter is correctly positioned in the jugular bulb. Third, we measured haemoglobin oxygen saturation by mean of a co-oximeter, the reference method based on three wavelength spectrophotometry, while Datsur et al used a two wavelength spectrophotometric method, and Gibbs et al the Van Slyke manometric method. The two latter methods overestimate oxygen saturation compared with the co-oximeter, particularly for the lower range of oxygen saturation, as is the case in venous samples.

**Normal SjO₂ limit lower than previously recognised: does it matter?**

SjO₂ values below the lower normal limit have been defined as jugular desaturation—that is, situations of critical inadequacy of CBF to CMRO₂, “from norms defined by Gibbs and coworkers,” and have been proven in a single study to independently affect the outcome of severe head trauma. However, the methods on how to summarise insult data such as jugular desaturation have only recently been defined, while in previous studies the jugular desaturation was simply dichotomised as present or absent, based on Gibbs’ data. Therefore, a new limit could modify the result. More

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**Table 1 Oxygen saturation values in the jugular bulb (SjO₂)**

<table>
<thead>
<tr>
<th>SjO₂</th>
<th>Present series</th>
<th>Gibbs (1942)</th>
<th>Datsur (1963)</th>
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<tbody>
<tr>
<td>Mean (95% CI)</td>
<td>57.1 (52.3 to 61.4)</td>
<td>62.0 (61.0 to 63.1)</td>
<td>64.3 (62.4 to 66.2)</td>
</tr>
<tr>
<td>Upper limit (95% CI)</td>
<td>69.5 (61.2 to 77.7)</td>
<td>69.4 (67.6 to 71.2)</td>
<td>73.7 (70.4 to 76.9)</td>
</tr>
<tr>
<td>Lower limit (95% CI)</td>
<td>44.7 (34.5 to 53.0)</td>
<td>54.6 (52.8 to 56.5)</td>
<td>55.0 (51.7 to 50.2)</td>
</tr>
</tbody>
</table>

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importantly, it is suggested that jugular desaturations, variously defined as $S_jO_2$ less than 50% or 54%,1 are treated aggressively, although benefits are unproven. A new normal limit further weakens the legitimacy of such treatments.

This study included a small sample of patients and therefore conclusions should be taken cautiously. Due to the lack of invasiveness that can be attributed to the method itself, our results can be easily replicated. If the normal lower $S_jO_2$ limit is confirmed to be as low as 46%, redefinition of “normality” applied to $S_jO_2$ may have diagnostic, prognostic, and therapeutic implications.

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REFERENCES
Carpenter ranked Ferrier’s cerebral localisation among the greatest advances in the physiology of the nervous system made in the past 50 years.1 It formed a direct link between Jackson and Sherrington, with both of whom he had worked.

Born in Aberdeen, Ferrier studied there under Alexander Bain, on whose advice in 1864 he visited Heidelberg, to study psychology with Helmholtz and Wundt. Wundt had just (1862) completed the Beiträge zur theorie der sinneserkranknungen that contained the first statement of his “psychological physiology”. Ferrier completed his medical training at Edinburgh where Thomas Laycock,2 inclined him towards neurology.

He worked in London from 1880, and was appointed Professor of Neuropathology, King’s College Hospital, in 1889. But his research began earlier at The West Riding Lunatic Asylum, Wakefield. There he showed that stimulation of the cerebral cortex could produce movements and fits, and that cerebral functions were localised in definable discrete areas. Before him, in 1886, Friedrich Albert Lange (1828–75) had distinguished between localisation of function and localisation of symptoms. Broca, Bouillaud,3 Fliourens,4 and others had tried to relate behaviour, language, and disease to different areas of the brain, but Franz Joseph Gall’s (1758–1828) phrenology was still accepted by many.5 Influenced by Bain and Spencer, Ferrier6 tested Hughlings Jackson’s notion that motor and sensory functions must be represented in an organised fashion in the cortex. Gustav Theodor Fritsch and Eduard Hitzig in 1870, using galvanic stimulation of the cerebrum in the dog,7 had recently shown that circumscribed cortical areas control movements of the contralateral limbs and that ablation of these areas caused weakness in these limbs. Their findings established electrophysiology as an experimental tool and showed the localisation of motor function in the hemispheres.

Ferrier used faradic rather than galvanic current to elicit movements that resembled primate walking, grasping, scratching, and thereby confirmed and extended the results of Fritsch and Hitzig. Ferrier localised smell in the uncus of the temporal lobe; hearing in the superior temporal operculation; and primary vision in the angular gyrus, although this was later corrected by Munk’s discovery of the occipital visual cortex. Ferrier used both ablation and electrical stimulation to produce topography of localisation of function in several areas.

Removal of the precentral gyrus, he found, caused paralysis and a hemiplegic position of the contralateral limbs. In 1876 he collected his results to produce his acclaimed The functions of the brain.8 This demonstrated that ablations and faradic stimulation of the brain were better than the galvanic techniques of Fritsch and Hitzig. He had thereby mapped sensory and motor areas across several species, thus expanding both understanding of and localisation of motor and sensory functions.9–11

Ferrier also performed decerebration experiments to distinguish between voluntary and reflex movement, and examined the control of eye movements by electrical stimulation of the cerebellum. He was not obsessed by the anatomical localisation. The functions of the cerebrum were sensorimotor.

“From the complexity of mental phenomena and the participation in them of both motor and sensory substrata, any system of localization of mental faculties which does not take both factors into account must be radically false.” He thus anticipated 20th century holistic concepts of cerebral function.

“Ferrier was more than an experimenter; he was, rather, a philosopher who did not philosophise but who experimented,” remarks Rioch.12

By making lesions in the anterior frontal cortex, he deduced the effect on function: “while not actually deprived of intelligence ... they had lost the faculty of attentive and intelligent observation.”

Thus, the frontal lobes might subserve the function of selection and inhibition of competing ideas.

He dedicated his work to Jackson:

“To Dr Hughlings Jackson who from a clinical and pathological standpoint anticipated many of the more important results of recent experimental investigation into the functions of the cerebral hemispheres, this work is dedicated as a mark of the author’s esteem and admiration.” Ferrier The functions of the brain (1876).

Jackson, similarly, had been inspired by Spencer and frequently cited his writings. Sherrington, in turn, dedicated his lectures on The integrative action of the nervous system (1906) to Ferrier. And in his obituary notice of Ferrier for the Royal Society, “Sherrington remarked:

“Ferrier has done the most important research in proving cerebral localization, in placing it at the centre of neurological interest, and in providing the basis for a scientific phrenology.”

He continued his clinical work applying these experimental findings to patients, and encouraging surgeons to operate on intracranial lesions; thus, Rickman Godlee said he was a powerful force in initiating brain surgery.

Among many honours, he received an Hon DSc, University of Cambridge, in 1914 and in 1911 a Knighthood. He was elected FRS in 1876, FRCP in 1877, and Goulstonian Lecturer in 1878. Not least of this great pioneer’s achievements was the foundation of the journal Brain, with Hughlings Jackson, Sir John Bucknill, and Sir James Crichton-Browne.

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