

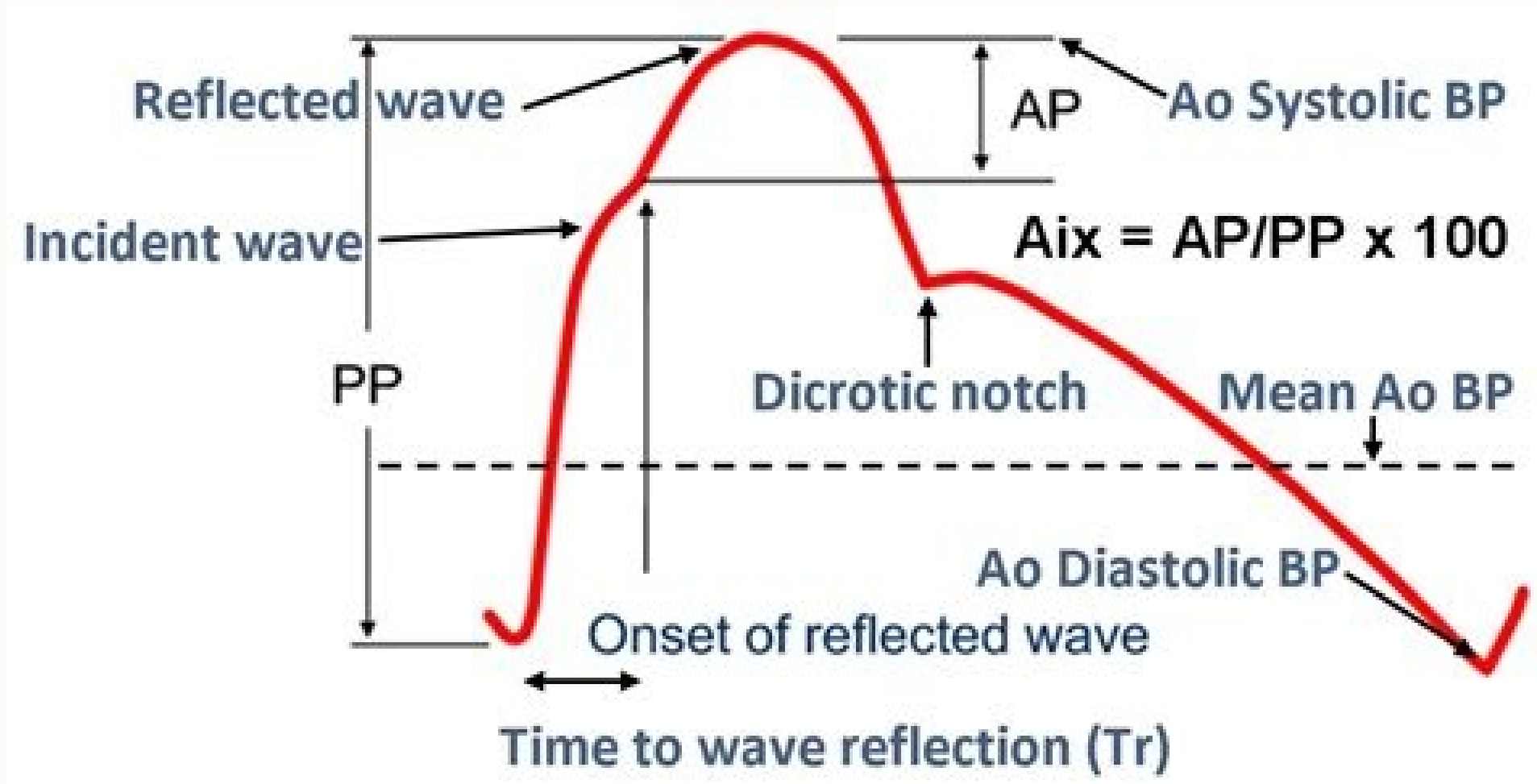
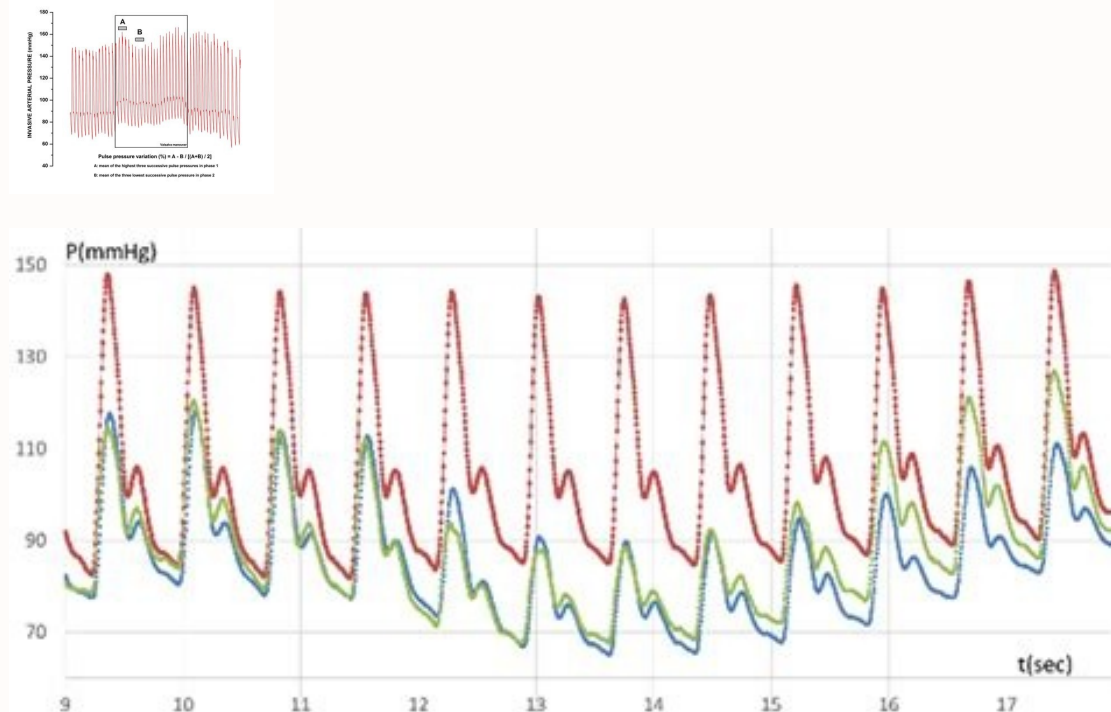
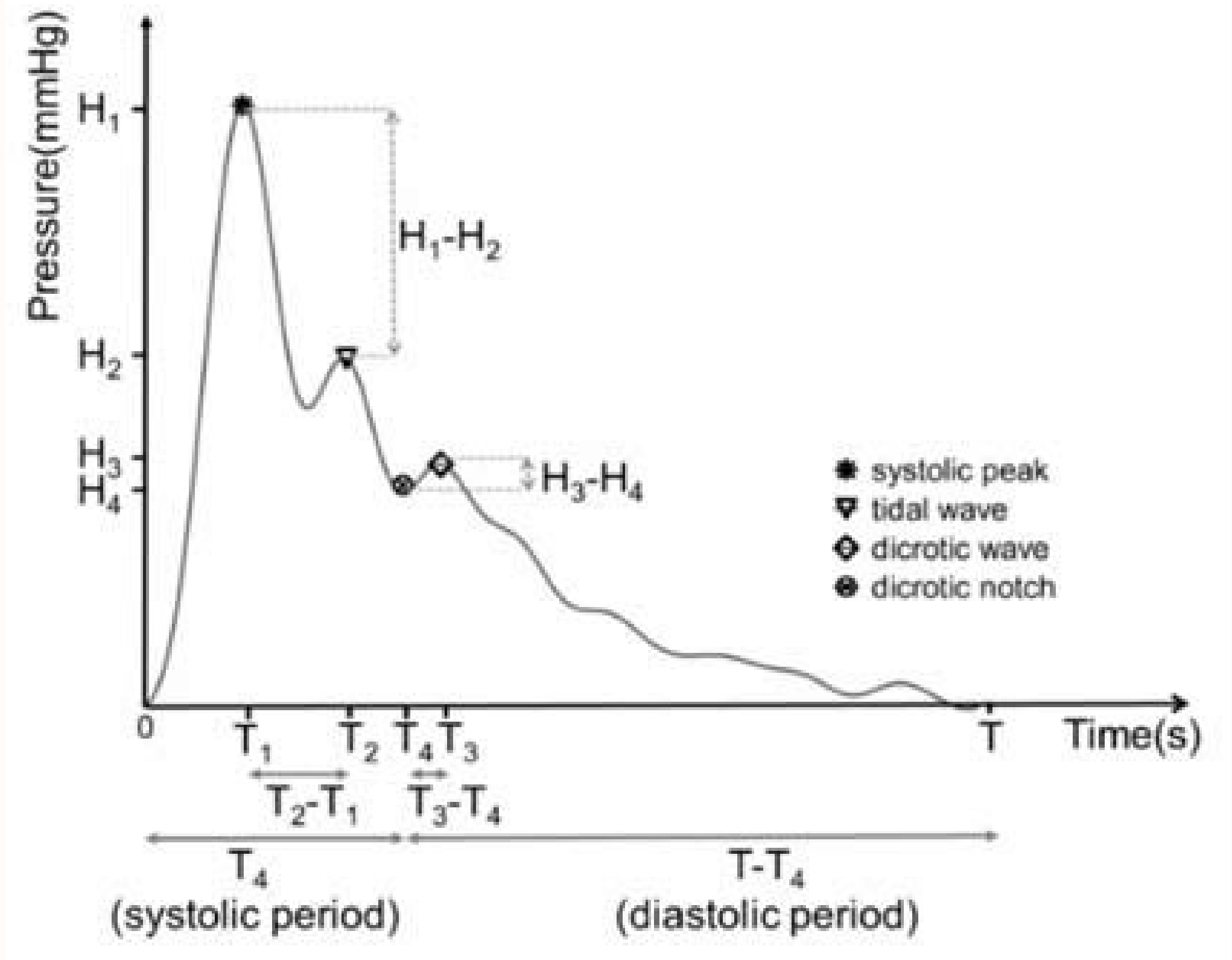
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Pulse pressure variation arterial waveform



Arterial pulse pressure variation. Pulse pressure variation arterial line. Pulse pressure variation values.

The intensity of the pulse is determined by blood pressure as well as other physiological factors such as ambient temperature. It is palpated proximal to the elbow between the medial epicondyle of the humerus and the distal biceps tendon. The carotid is the preferred pulse point used during resuscitation of adults. In the lower extremities, the commonly evaluated pulses are the femoral, posterior tibial, dorsalis pedis, and sometimes the popliteal. The femoral pulse may be the most sensitive in assessing for septic shock and is routinely checked during resuscitation.[3] It is palpated distally to the inguinal ligament at a point less than halfway from the pubis to the anterior superior iliac spine. The posterior tibial pulse may be the most difficult to palpate, especially among less experienced clinicians.[4] It is located immediately posterior to the medial malleolus.[5] The dorsalis pedis is at the anterior aspect of the foot, lateral to the extensor hallucis tendon, and is generally within 1cm of the bony prominence of the navicular bone.[6] Therefore, asking the patient to extend their first toe can help elevate this landmark and may make the pulse easier to identify, although it may be absent due to an anatomical variation in 10% of the general population.[1] Finally, the popliteal pulse is present in the popliteal fossa slightly lateral of the midline. In addition to manual palpation, there are medical technologies that can detect pulse and study the waveform objectively. Doppler ultrasound is non-invasive, so it is often an option if the clinician cannot palpate a pulse manually. Palpation of peripheral pulses in a patient with strong systolic blood pressure in a controlled setting by an experienced clinician is an important and reliable physical examination skill. However, several studies show that when those ideal conditions degrade through the presence of pathology, time or environmental pressures, or inexperience of the clinician, the reliability of the clinical exam decreases. In these cases, modern medical technology, as mentioned above, can assist in assessing peripheral pulses and determining the presence of pathology. The heart rate can be obtained through many devices routinely applied to the body in most medical encounters anywhere from the prehospital setting to the intensive care unit. While obtaining a heart rate is valuable, there are many instances in which recording the peripheral pulse is desirable and increases the quality of patient care. Peripheral pulses are clinically useful in identifying specific vascular pathologies, including peripheral arterial disease, vasculitis, congenital abnormalities, and others. Lower extremity peripheral pulses can be used to effectively screen for peripheral arterial disease (PAD). Traditionally, the screening tool for PAD is the ankle-brachial index (ABI), which compares the systolic blood pressure in the ankle to that in the arm. For example, colder temperatures cause vasoconstriction leading to decreased intensity.[1] Besides the normal variation in a rhythm that occurs with the respiratory cycle, the heart rate should be regular in the absence of pathology. Pathological conditions can alter the rate, rhythm, intensity, and symmetry of the peripheral pulses, a fact that physicians can exploit when evaluating a patient. How to Perform Pulses are accurately measured when the clinician places their fingertips onto the skin overlying the vessel (locations, see below) and focuses on different aspects of the pulse. It is crucial to note that pulselessness is an unreliable sign of compartment syndrome, although clinicians commonly use it for this purpose.[8] The last two categories of pathology affecting peripheral pulses include vasospasm, as in Raynaud phenomenon, and congenital anatomic abnormalities.[1] Peripheral pulses are part of a thorough physical examination used to assess for coarctation of the aorta. By convention, "plus" always follows the number (e.g., 1+). With 60 to 80% of infants going home undiagnosed with this condition after birth, there have been proposals for attention to this aspect of the physical exam in neonates as a possible means of improving patient care through increased detection of coarctation.[9] Peripheral pulse observation and recording is a useful assessment because of how quickly and easily it can be performed without specialized equipment or added cost. It is commonly used to continue evaluating patients who may have had trauma, sepsis, or other forms of shock, as well as a screening tool for pathologies such as PAD. Many types of clinical providers are trained to perform pulses, including nurses and physicians, and all those in the healthcare field who have taken a CPR course. Clear documentation is essential when talking about pulses in the electronic medical record, indicating the location of the pulse, on which side, the results, and if it has changed from previous assessments. Sometimes peripheral pulses are marked with an "X" on the patient's skin so that there is continuity of care as different clinicians evaluate the patient over time. Some of the more commonly used technologies with this capability include Doppler ultrasound and arteriography, while other technologies for monitoring peripheral vasculature are also emerging.[5] Arteriography and ultrasound are two methods that can provide a discrete waveform. Therefore they know where the previous clinicians found the pulse and that it was present. This test is somewhat time-consuming and requires specific equipment and training. However, a study has shown that when screening for PAD, if a patient has both pedal pulses intact bilaterally, the clinician could forgo ABI testing, as the likelihood of the patient having PAD, in that case, was under

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