Office Spirometry in Primary Care Pediatrics: A Pilot Study

Stefania Zanconato, MD, PhD*; Giorgio Meneghelli, MD‡; Raffaele Braga§; Franco Zacchello, MD*; and Eugenio Baraldi, MD*, on behalf of the Working Group

ABSTRACT. Objective. The aim of this study was to investigate the validity of office spirometry in primary care pediatric practices.

Methods. Ten primary care pediatricians undertook a spirometry training program that was led by 2 pediatric pulmonologists from the Pediatric Department of the University of Padova. After the pediatricians’ training, children with asthma or persistent cough underwent a spirometric test in the pediatrician’s office and at a pulmonary function (PF) laboratory, in the same day in random order. Both spirometric tests were performed with a portable turbine flow sensor spirometer. We assessed the quality of the spirometric tests and compared a range of PF parameters obtained in the pediatricians’ offices and in the PF laboratory according to the Bland and Altman method.

Results. A total of 109 children (mean age: 10.4 years; range: 6–15) were included in the study. Eighty-five (78%) of the spirometric tests that were performed in the pediatricians’ offices met all of the acceptability and reproducibility criteria. The 24 unacceptable test results were attributable largely to a slow start and failure to satisfy end-of-test criteria. Only the 85 acceptable spirometric tests were considered for analysis. The agreement between the spirometric tests that were performed in the pediatrician’s office and in the PF laboratory was good for the key parameters (forced vital capacity, forced expiratory volume in 1 second, and forced expiratory flow between 25% and 75%). The repeatability coefficient was 0.26 L for forced expiratory volume in 1 second (83 of 85 values fall within this range), 0.30 L for forced vital capacity (81 values fall within this range), and 0.58 L/s for forced expiratory flow between 25% and 75% (82 values fall within this range). In 79% of cases, the primary care pediatricians interpreted the spirometric tests correctly.

Conclusions. It seems justifiable to perform spirometry in pediatric primary care, but an integrated approach involving both the primary care pediatrician and certified pediatric respiratory medicine centers is recommended because effective training and quality assurance are vital prerequisites for successful spirometry.

From the *Department of Pediatrics, University of Padova, Padova, Italy; ‡Primary Care Pediatrics, Federazione Italiana Medici Pediatri, Italy; and §Valeasp SpA, Milano, Italy.

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Address correspondence to Stefania Zanconato, MD, PhD, Department of Pediatrics, University of Padova, Via Giustiniani 3, 35128 Padova, Italy. E-mail: zanconato@pediatria.unipd.it

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ABBREVIATIONS. PF, pulmonary function; FEV1, forced expiratory volume in 1 second; ATS, American Thoracic Society; FVC, forced vital capacity; FET, forced expiratory time; FEF25–75, forced expiratory flow between 25% and 75% of expired FVC; ICC, intraclass correlation coefficient; GP, general practitioner.
No previous studies have formally assessed spirometry performance in primary care pediatric practice. We aimed to determine the quality of the spirometric tests that are performed in primary care pediatric practice after formal training for the pediatrician was provided. For this purpose, spirometric tests that were performed by primary care pediatricians were assessed for acceptability and reproducibility, and the resulting spirometric data were compared with those obtained at a PF laboratory using the same portable spirometer. The primary care pediatrician’s interpretation of the spirometric data were also assessed. Finally, to validate the portable spirometer, the data that it produced in the laboratory were compared with those that were obtained with a gold-standard laboratory-based volume spirometer.

METHODS

The study was a repeated, cross-sectional, within-subject comparison of spirometric tests in a PF laboratory and in primary care pediatricians’ offices. The study involved 10 primary care pediatricians from northeast Italy and 2 pediatric pulmonologists at the Pediatric Allergy and Pulmonology Unit of the University of Padova, which is a certified European Respiratory Society center for pediatric respiratory medicine training. Children who had a diagnosis of asthma or cough persisting for >15 days and were aged 6 to 15 years were selected for the study (Table 1). They were recruited during routine visits to the pediatricians’ offices. All parents gave their written informed consent.

Training

A spirometry training program that consisted of two 5-hour sessions separated by an interval of 12 weeks was arranged for the primary care pediatricians. During each session, 2 pediatric pulmonologists (S.Z. and E.B.) reviewed respiratory system physiology, general aspects of asthma, indications for spirometry, basic spirometry test performance issues and the interpretation of spirometric indices, and flow-volume and volume-time curves. The practical part included a demonstration of the Microloop turbine flow sensor spirometer (Micro Medical Limited, Rochester, UK) and Spida 5 software (Micro Medical Limited) that was to be used for the study, individual practice with spirometry testing, and interpretation. During the 12-week interval between the first and second sessions, the participants were required to perform at least 30 spirometric tests and could share their experience and problems encountered using spirometry in their practice with the 2 pediatric pulmonologists. In addition, they were assisted in their offices for technical problems. During the first training session, participants were given a manual on the theoretical and practical aspects of spirometry, paying particular attention to acceptability and reproducibility criteria and test interpretation.

<table>
<thead>
<tr>
<th>TABLE 1.</th>
<th>Patient Characteristics and Lung Function Data</th>
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<tr>
<td>Characteristic</td>
<td>Value</td>
</tr>
<tr>
<td>N (male)</td>
<td>109 (74)</td>
</tr>
<tr>
<td>Age, y; mean (range)</td>
<td>10.4 (6–15)</td>
</tr>
<tr>
<td>FVC, % predicted</td>
<td>100 (93–105)*</td>
</tr>
<tr>
<td>FEV1, % predicted</td>
<td>98 (81–107)*</td>
</tr>
<tr>
<td>FER25–75, % predicted</td>
<td>81 (67–92)*</td>
</tr>
<tr>
<td>FEV1/FVC, %</td>
<td>84 (79–88)*</td>
</tr>
</tbody>
</table>

* Data are expressed as median and interquartile range (IQR) of the spirometric results. The 85 acceptable spirometric tests that were performed in primary care pediatric offices were considered for analysis.

Spirometry Tests

Data collection started after the second training session and lasted for 1 month. The pediatricians’ offices and laboratory all were equipped with the same portable spirometer (Microloop) and spirometry computer software (Spida 5). The spirometer uses a turbine flow sensor. The unit is provided with built-in quality assurance features, based on American Thoracic Society (ATS) criteria. The spirometry software displays real-time flow-volume and volume-time curves and produces built-in quality assurance prompts, which are displayed after each unacceptable blow (eg, slow start, abrupt end, short blow) and to indicate the variability between the 2 highest FEV1 and forced vital capacity (FVC) values. Spirometers were checked for reading errors by a technician before the study began, using a certified 3-L syringe. All spirometers had a deviation of <3% in the volume reading.

Patients were instructed to abstain from short-acting bronchodilators for 8 hours and long-acting bronchodilators for 12 hours before taking the test. Each patient underwent 2 spirometric tests (forced expiratory maneuvers) in random order in the same day. One test was performed at the pediatrician’s office; the other was performed at the PF laboratory by 1 of the pulmonologists. Both the pediatricians and the pulmonologists were unaware of the results of the other spirometric test. All spirometric tests were conducted with the patient standing and wearing a nose clip. Patients were instructed to inhale completely before inserting the mouthpiece while holding their breath, then exhale forcefully into the spirometer for as long as they could. At least 3 acceptable and reproducible forced expiratory maneuvers were required for each test. Table 2 shows the acceptability and reproducibility criteria. According to ATS recommendations, a forced expiratory time (FET) of <6 seconds is acceptable in children, and we considered a FET ≥2 seconds as acceptable. The expiratory spirometric indices (including FEV1 and FVC) of the maneuver with the highest sum of FEV1 + FVC were saved and used for analysis. Flow-volume and volume-time curves and spirometric parameter results were printed.

To validate the portable spirometer against a gold-standard spirometer, a group of 55 patients with asthma (38 boys; mean age: 10.2 years) performed 1 spirometric test in the PF laboratory with a 10-L bell spirometer (Biomedin, Padova, Italy) and 1 with the portable Microloop turbine spirometer. The order in which the devices were used was varied systematically. The results of the 2 tests were compared.

Outcomes and Statistical Analysis

Acceptability Criteria

Individual spiromograms were judged to be “acceptable” when all of the following requirements were met: good start (as defined by a back extrapolated volume <5% of FVC), satisfactory exhalation for ≥2 seconds, no abrupt end, and no cough during the maneuver (Table 2).

Reproducibility Criteria

After 3 acceptable spirometric tests had been identified, the test was judged to be reproducible when the two highest FVC and FEV1 values were within 5% of each other.

Comparison Between Pediatricians’ Offices and Laboratory Spirometric Tests With the Portable Spirometer

One of the primary outcomes was the within-subject difference between laboratory and primary care office spirometric test re-
between the 2 spirometric test results, crude mean and the PF laboratory were compared using an intraclass correlation coefficient (ICC). These records then were reviewed by the 2 pediatric pulmonologists, who marked the primary care pediatrician’s interpretations as “correct” or “incorrect.”

Statistical Analysis

For the statistical analysis, we performed a power calculation that showed that we needed 85 patients per spirometry group to have 80.3% power to detect a 7% or greater difference in spirometric parameters between spirometry performed in the pediatric office and in the PF laboratory (with α set at 5%). FVC, FEV₁, and FEF25–75 values are expressed as median and interquartile range. FVC, FEV₁, and FEF25–75 of the spirometry tests that were performed with the portable spirometers in the pediatricians’ offices and the PF laboratory were compared using an intraclass correlation coefficient (ICC). In addition, for assessing the agreement between the 2 spirometric test results, crude mean ΔFVC, ΔFEV₁, and ΔFEF25–75 were calculated by subtracting a patient’s laboratory value from the pediatric practice value. Mean values for these parameters with 95% confidence interval were calculated, and difference versus mean plots and accompanying limits of agreement (±1.96 times the SD of the differences) were produced to express the variability between laboratory and pediatric practice measurements according to the Bland and Altman method.24 The Bland and Altman method was used to assess the agreement between the spirometric parameters that were obtained in the PF laboratory with the portable and the laboratory-based volume spirometers.

RESULTS

A total of 109 patients (74 boys) were included in the study (Table 1). Their mean age was 10.4 years (range: 6–15 years). Thirty-four (31%) patients had never had a spirometric test before. Ninety-eight (80.3%) patients aged between 25% and 75% of expired FVC (ΔFVC).

Differences in FEV₁ between pediatrician’s office (ped) and PF laboratory spirometry plotted against mean FEV₁ values. The dashed horizontal lines indicate the limits of agreement (mean difference ±1.96 times the SD of the differences).

Each pediatrician performed at least 9 spirometric tests.

Comparison of Tests That Were Performed With the Portable Spirometer in Pediatric Practices and at the PF Laboratory

Only acceptable spirometric tests were compared. Matched pairs of laboratory and pediatricians’ office tests were available for 85 patients. The agreement of the FEV₁, FVC, and FEF25–75 measurements that were obtained from each patient in the pediatric practice and in the laboratory was expressed using ICC, which is an estimate of the correlation between 2 measurements from 1 patient. We found very high values of ICC for the spirometric parameters that were measured in the pediatric practice and in the laboratory (Table 4). Figures 1, 2, and 3 show a curve-by-curve comparison of the differences between the 2 locations versus the mean for each of the key parameters (FVC, FEV₁, and FEF25–75) according to the Bland and Altman method. There was a good agreement between the pediatrician’s office and the laboratory’s spirometric tests for all 3 parameters. The repeatability coefficient was 0.26 L for FEV₁ (with 83 of 85 values falling within this range), 0.30 L for FVC (with 81 values falling within this range), and 0.58 L/s for FEF25–75 (with 82 values falling within this range). The scatter of the ΔFEV₁, ΔFVC,
and ΔFEF25–75 values did not vary systematically over the range of measurements.

**Interpretation of the Spirometric Test Results**

The pediatrician’s interpretation was judged to be incorrect in 23 (21%) of 109 patients’ tests. The interpretation errors are given in Table 5. In 15 cases, the test result was interpreted as normal, when it actually revealed mild obstruction in 11 cases and volume restriction in 4. In another 3 patients, the obstruction was underestimated, and in the last 5 cases, the obstruction was overestimated.

**Comparison Between the Spirometric Tests That Were Performed at the PF Laboratory With the Portable and the Laboratory-Based Volume Spirometers**

Matched pairs of spirometric tests that were performed in the PF laboratory with the portable and the laboratory-based volume spirometers were available for 55 patients. There was good agreement between the 2 spirometers for all 3 main spirometric parameters (FVC, FEV1, and FEF25–75). The repeatability coefficient was 0.14 L for FEV1 (with 53 of 55 values falling within this range), 0.18 L for FVC (with 52 values falling within this range), and 0.55 L/s for FEF25–75 (with 54 values falling within this range).

**DISCUSSION**

This is the first study to address formally the quality of spirometry that is performed in primary care pediatricians’ offices after a training program. The results of this study indicate that, on average, the quality of spirometric tests in primary care pediatric practice is satisfactory by comparison with a spirometric test performed in a PF laboratory, but 22% of the tests that were performed by the former were unacceptable, and 21% of them were misinterpreted.

Laboratory-based spirometry is the “gold standard” for assessing lung function in children with asthma, but the costs of the technician and equipment led to peak flowmeters often being used instead for office and home monitoring of lung function in children. Although peak expiratory flow monitoring and asthma diaries are useful tools in selected patients, there are major limitations to their widespread use in children with asthma. Portable spirometers are now available with the capability for collecting a wide range of PF parameters that are clinically and epidemiologically more useful than peak expiratory flow, because they are more sensitive to functional status changes in asthma.

The validity of spirometric tests is a prerequisite for their use as a tool for the diagnosis, monitoring, and management of respiratory diseases. Little is known about the validity of spirometric tests in adult patients in the primary care setting, however, and it has been reported that at least one third of the tests that are performed by the general practitioner (GP) fail to meet the quality criteria that are applicable to PF laboratories.

The validity of spirometric tests that are performed in general practice was investigated recently by Schermer et al by comparing them with the tests that are performed in patients with chronic obstructive pulmonary disease using the same spirometer at a PF laboratory. After a spirometry training program, the authors found the validity and the quality of the spirometric tests that were conducted by the GP’s satisfactory, but the consistency between the laboratory’s and the GP’s measurements seemed to be limited. No studies have hitherto formally addressed spirometry performance in primary care pediatric practice.
Although seemingly straightforward, spirometry is an effort-dependent test that requires a cooperative patient and a trained operator to administer the test. We used a spirometer with built-in quality assurance prompts on the assumption that this would improve the quality of the spirometry, but 22% of the tests nonetheless failed to meet the acceptability and reproducibility criteria. Most of the errors were attributable to slow start or short blow.

In our study, the children were instructed to exhale for as long as they could, and a FET $\geq 2$ seconds was considered valid. The ATS standards recommend an expiratory time of $\geq 6$ seconds in adult patients, but, recognizing that children have difficulty in meeting such end-of-test criteria, they say that shorter exhalation times are acceptable in children. Assuming that the flow-volume curve shows no abrupt termination of expiratory flow and that the volume/time curve shows a plateau, it has been suggested that the minimum FET should be reduced to 2 seconds for children who are $\geq 8$ years and to 1 second for children who are younger than 8 years. Other researchers suggested taking 3 seconds or 4 seconds as the target exhalation times.

A previous study in adult patients with chronic obstructive pulmonary disease demonstrated a slight but significant difference between the spirometric indexes that were measured by the GP’s staff and those that were measured at a PF laboratory, suggesting that an interchangeable use of these measurements should be avoided. We found no difference in FVC, FEV₁, and FEF₂⁰–₇₅ between the pediatrician’s and the PF laboratory’s results of tests that were performed with the portable spirometer. In addition, we demonstrated that the portable spirometer that we used provides an accurate and reliable measure of PF when compared with a gold-standard laboratory-based device, as shown by the consistency that emerged between the 2 spirometers across the key spirometric parameters.

Although we primarily addressed the quality of the test’s performance, the pediatricians’ interpretation of the results was incorrect in 21% of the cases reviewed. In many cases, this misinterpretation involved the failure to detect or an understimation of airway obstruction, so any clinical decisions that are based on these results would compound, rather than reduce, the underdiagnosis and undertreatment of asthma. Accurate interpretation relies not only on a well-performed procedure but also on an appreciation of physiology and a thorough clinical knowledge of the patient. Of course, longer, more intensive training might have produced better results in terms of the interpretation of the findings.

Proper training for the technician/physician who performs the test is perhaps the most important factor in ensuring good-quality spirometric testing. As stated in 1991 by the ATS, the largest single source of within-subject variability is improper performance of spirometry; therefore, effective training and quality assurance are vital prerequisites for successful spirometry. After adequate training, it is also important to have continual competence assessments and to review the test results carefully. It has been demonstrated that, even in a dedicated research setting paying meticulous attention to quality, a techni cian’s performance declines over time, but the quality of spirometry can improve dramatically and be maintained by routinely monitoring test session quality and prompting individual feedback.

In both the United States and Europe, there are accredited training centers for pediatric respiratory medicine with modules on PF testing. Because effective training and quality assurance are vital prerequisites for successful spirometry, we believe that only approved training centers for pediatric respiratory medicine should certify that a primary care pediatrician has acquired the competence for performing and interpreting a spirometric test.

In conclusion, with sufficient training for the physicians and their staff, it seems justifiable to perform spirometry in the pediatric primary care setting. This could improve asthma monitoring in children, as recommended by the international guidelines. If spirometry is to be promoted as a screening tool in primary care practice, however, then it is important to pay careful attention to ensuring that quality standards are met. To achieve this goal, an integrated approach is recommended, involving both the primary care pediatrician and the certified pediatric respiratory medicine centers.

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REFERENCES


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A conflict of interest declaration should appear in the article by Gastiasoro-Cuesta et al, titled “Acute and Sustained Effects of Lucinactant Versus Poractant-α on Pulmonary Gas Exchange and Mechanics in Premature Lambs With Respiratory Distress Syndrome” published in the February 2006 issue of Pediatrics (doi:10.1542/peds.2005-0378). Adolf Vallis-i-Soler freely declares a potential conflict of interest because he has received support from Discovery and Esteve Laboratories to perform these experiments. He has also received support from Chiesi for basic and clinical studies as well as consultancy fees. The other authors have no relevant financial relationships to declare.

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An error appeared in the article by Zanconato et al, titled “Office Spirometry in Primary Care Pediatrics: A Pilot Study” published in the December 2005 issue of Pediatrics Electronic Pages (doi:10.1542/peds.2005-0487). The legends for figures 1 and 2 were switched. On page e794, column 2, Figure 1, the legend should read as follows: “Fig 1. Differences in FVC between pediatrician’s offices (ped) and PF laboratory spirometry plotted against mean FVC values. The dashed horizontal lines indicate the limits of agreement (mean difference \pm 1.96 times the SD of the differences).” On page e795, column 1, Figure 2, the legend should read as follows: “Fig 2. Differences in FEV1 between pediatrician’s office (ped) and PF laboratory spirometry plotted against mean FEV1 values. The dashed horizontal lines indicate the limits of agreement (mean difference \pm 1.96 times the SD of the differences).” We regret the error.

doi:10.1542/peds.2006-0941


Several errors appeared in the article by Macpherson et al, titled “Body-Checking Rules and Childhood Injuries in Ice Hockey” that was published in the February 2006 issue of Pediatrics Electronic Pages (doi:10.1542/peds.2005-1163). Due to a coding error, the youngest and oldest age groups were inverted affecting the odds ratios, confidence intervals, and tables throughout the text. The following changes should be noted:

Page e143, Abstract, Results section should read as follows:

“Results: Of the 4736 hockey injuries, 3006 (63%) were in Ontario and 1730 (37%) were in Quebec. Most of the injuries occurred in areas where check-
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