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ORIGINAL ARTICLE

A procedure for determining subject-specific pulse oxygen saturation response

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Abstract
The oxyhemoglobin dissociation curve describes the relationship between the partial pressure of oxygen and the percent of hemoglobin saturated with oxygen and varies with chemical and physical factors that differ for every patient. If variability could be determined, patient-specific oxygen therapy could be administered. We have developed a procedure for characterizing variations in the oxygen dissociation curve. The purpose of this study was to validate this procedure in surgical patients. The procedure uses an automated system to alter oxygen therapy during surgery, within safe operational levels, and fit to Hill's equation non-invasive measurements of end-tidal oxygen and peripheral pulse oxygen saturation. The best-fit parameters for the Hill equation, estimated by iterative least squares, provide an apparent dissociation curve, meaningful of the patient-specific pulse oximeter response. Thirty-nine patients participated in this study. Using patient-specific parameter values increases correlation when compared with standard values. The procedure improved the model fit of patient saturation values significantly in 19 patients. This paper has demonstrated a procedure for determining patient-specific pulse oximeter response. This procedure determined best-fit parameters resulting in a significantly improved fit when compared with standard values. These best-fit parameters increased the coefficient of determination R^2 in all cases.

Keywords Subject-specific modeling · Non-linear least-squares · Oxygen saturation response · The Hill equation

1 Introduction

The oxyhemoglobin dissociation curve (ODC) describes the relationship between the percent of hemoglobin saturated with oxygen (SHbO2) and the partial pressure of oxygen (PO2) in the blood [8, 9, 13, 19, 23]. Due to the allosteric effects of oxygen binding with hemoglobin's four oxygen binding sites, this response is a sigmoidal curve [3, 20]. Due to hemoglobin's affinity for oxygen, this sigmoid relationship plateaus at a PO2 of approximately 150 mm Hg in healthy patients [19]. Above 150 mm Hg, the majority of hemoglobin binding sites are fully saturated with oxygen, and thus SHbO2 is minimally responsive to changes in PO2 while below 150 mm Hg, SHbO2 is highly responsive to changes in PO2 [1]. These characteristics of oxyhemoglobin's response to PO2 permit oxygen uptake in the lungs, at high PO2, and oxygen unloading near tissue, at low PO2, and are vital to oxygen transport in the body [15].

Besides oxygen, hemoglobin is responsive to other notable allosteric effectors [9, 25, 27, 28]. These include chemical factors in the blood such as hydrogen ions (pH), carbon dioxide (CO2), and 2,3-Diphosphoglycerate (2,3-DPG) [5]. Hemoglobin's allosteric effectors also include the physical factor of temperature (T). Although the effects of factors are well characterized, the values of the factors are not clinically available in many patients. Patient to patient variation in the concentrations and levels of these effectors, in turn, can effect hemoglobin's affinity for oxygen. Differences in oxygen affinity can affect the position and shape of the ODC, with increased oxygen affinity shifting the curve to the left (lower PO2) and decreased affinity shifting the curve to the right [19]. Thus, hemoglobin's affinity for oxygen varies from patient to patient [26].

Variations in oxygen affinity change the shift and shape of the ODC, including the PO2 at which the ODC transitions from a plateau to a steep slope. This patient-to-patient variability impacts the level of oxygen therapy required to prevent desaturation. However, if a patient-specific ODC

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could be generated, the transition from the plateau to sharp curve could be characterized, and patient-specific oxygen therapy could be administered, preventing desaturation. One possibility for determining patient variability is to create an automated procedure which uses a set of PO2 and pulse oxygen saturation (SpO2) value pairs to fit a patient-specific ODC. We have developed such a procedure which is based on an automated oxygen delivery system and Hill's equation.

The procedure measures several levels of oxygen saturation by varying oxygen therapy using an automated system. Best-fit parameters (P_{50}, n, K) for corresponding saturation and oxygen measurements are then found using an iterative minimal least-squares technique. Once these parameters are found, the procedure constructs an apparent patient-specific ODC from which important characteristics, including the transition from the plateau to the steep slope of the curve, can be obtained. Extrapolation of the apparent ODC could also be used to predict a patient-specific response to different levels of oxygen therapy.

The objective of this study was to validate the procedure for determining patient-specific pulse oxygen saturation response. If validated, the procedure could characterize patient-specific oxyhemoglobin using an automated system and non-invasive techniques.

2 Methods

This study was performed in accordance with the 1964 Helsinki declaration and its later amendments or comparable standards. Study approval came from the University of Utah Institutional Review Board. All patients participated with written informed consent.

2.1 Procedure for characterizing oxygen saturation response

The procedure for characterizing pulse oxygen saturation response uses an automated system to alter oxygen therapy to generate patient-specific oxygen flow and saturation data pairs. Hill's equation is then used to characterize the data set for each patient. To determine oxygen saturation response, the automated system administers different levels of oxygen therapy gathering measurements for oxygen and saturation levels at each level. The procedure then uses iterative least squares residual techniques to find the best-fit curve for the gathered measurements.

2.1.1 Automated oxygen therapy system

Figure 1 shows a schematic diagram of the automated oxygen therapy system which includes a laptop computer for collecting data. The automated system varies oxygen flow rate using a proportional solenoid valve (MD PRO, Parker Hannifin, Hollis, NH) connected to a source of compressed oxygen. A laptop computer collects end-tidal oxygen (etO2) measurements from a gas analyzer (CapnoMAC, Datex, Helsinki, Finland). The laptop computer also collects SpO2 from a pulse oximeter (LNCS^{TM}, Masimo, Irvine, CA). The system monitors nasal pressure to determine breath phase and discontinues oxygen flow during exhalation so that etO2 measurements are not contaminated by supplemental oxygen [18, 29]. Further information describing the method used to deliver oxygen and measure etO2 is given in Section 2.3. An automated oxygen therapy system with similar underlying characteristics and developed by the authors has been described previously, see [7] and [6] for a detailed description.

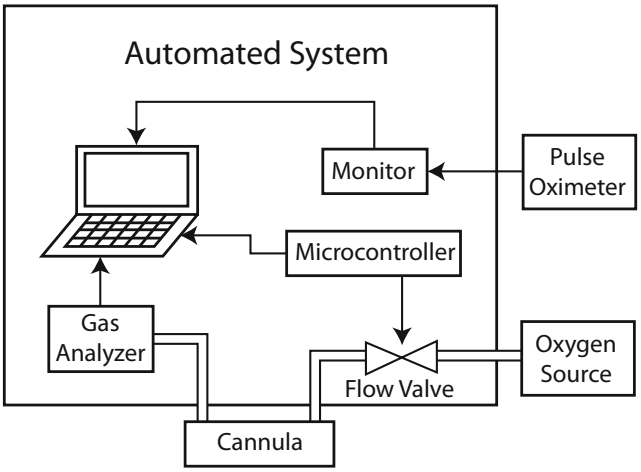

Fig. 1 Schematic diagram of the automated system

2.1.2 Theoretical aspects

While varying oxygen, the procedure collects pairs of etO2 and SpO2 measurements. Since the system varies oxygen, a range of SpO2 measurements can be measured to characterize a patient's ODC. After collecting pairs of measurements, the procedure fits the data to Hill's equation:

$$SHbO2 = f(PO2) = K\frac{(PO2/P_{50})^n}{1+(PO2/P_{50})^n}, \quad (1)$$

where P_{50} is the $PO2$ at which 50% of hemoglobin are saturated with oxygen ($SHbO2 = 50\%$), n is the Hill coefficient, and K is the maximum saturation possible.

Hill's Equation can be used to calculate SHbO2 for any given PO2. Its three variables can be used to determine ODC shift (P_{50}), slope (n), and offset (K). The value of these three variables depends on the conformation of hemoglobin and thus varies between patients.

2.1.3 Determining the best-fit parameters

The procedure finds the best-fit P_{50}, n, and K values for each volunteer using iterative non-linear least-squares fitting as implemented in the *least_squares* function of the *optimize* module in *SciPy* (SciPy, v1.1.0, The SciPy community) [21].

The solution to a non-linear least-squares problem is a local minimizer of the problem:

$$\min\left\{\sum_{i=1}^{m} f_i(x)^2\right\}, \tag{2}$$

where m is the number of residuals [2]. For analyzing pulse oxygen saturation response, the problem is of the form:

$$f_i(\mathbf{x}) = K\frac{(PO2_i/P_{50})^n}{1+(PO2_i/P_{50})^n} - SpO2_i, \tag{3}$$

where $PO2_i$ (independent) and $SpO2_i$ (dependent) are the ith measured SpO2 and etO2 points, respectively. The patient-specific parameters are contained in $\mathbf{x} = \{P_{50}, n, K\}$. The gradient vector elements in parameter space, which are helpful for computing the minimization problem, can be found using the following equations:

$$J_{i0} = \frac{\partial f_i}{\partial P_{50}} = -\frac{Kn}{P_{50}}\frac{(PO2_i/P_{50})^n}{[1+(PO2_i/P_{50})^n]^2} \tag{4}$$

$$J_{i1} = \frac{\partial f_i}{\partial n} = K\log(PO2_i/P_{50})\frac{(PO2_i/P_{50})^n}{[1+(PO2_i/P_{50})^n]^2} \tag{5}$$

$$J_{i2} = \frac{\partial f_i}{\partial K} = \frac{(PO2_i/P_{50})^n}{1+(PO2_i/P_{50})^n} \tag{6}$$

where log is the natural logarithm and values in $\mathbf{x}$ are all positive. The constraints for $\mathbf{x}$ are shown in Table 1.

2.1.4 Estimating oxygen saturation

After the best-fit parameters have been determined using the methods described in Section 2.1.3, the procedure proceeds by estimating oxygen saturation. This is done using the best-fit parameters, etO2 values, and Eq. 1. End-tidal oxygen values are converted to PO2 by compensating for local atmospheric pressure (640 mm Hg) and the partial pressure of water vapor at 37° C (47 mm Hg):

$$PO2 = (640-47)\frac{etO2}{100\%}\text{mm Hg} \tag{7}$$

Table 1 Constraints for $\mathbf{x} = \{P_{50}, n, K\}$

Parameter	Range	Units
P_{50}	15–75	mm Hg
n	1.5–3.9	Unitless
K	0.94–1.0	Unitless

2.2 Model fit assessment

Model fit assessment methods can be used to quantify how well the model performs. These assessment methods analyze how well the model describes data (descriptive error) and how well it predicts data (predictive error). For modeling oxygen saturation response, model description and prediction error can be analyzed to validate the ability of the procedure to fit and predict SpO2. This assessment was performed as described in the previous work of Dubreuil et al. and Donders et al. [10, 12].

Descriptive error can be determined by using the coefficient of determination ϵ_{R^2}:

$$\epsilon_{R^2} = 1 - \frac{\sum_{i=1}^{n}(y_i - f(x_i))^2}{\sum_{i=1}^{n}(y_i - \overline{y})^2}, \tag{8}$$

where f is the Hill equation with best-fit parameters for the particular data set $\mathbf{x}$, $f(x_i)$ represents model estimates computed using f and x_i, y_i are observed measurements, and $\overline{y}$ is the mean of all the y_i measurements:

$$\overline{y} = \frac{1}{n}\sum_{i=1}^{n} y_i \tag{9}$$

Here ϵ_{R^2} is descriptive because it represents the ratio of residual variance to total variance.

Leave-one-out cross-validation can be performed by calculating the predictive coefficient of determination ϵ_{Q^2}:

$$\epsilon_{Q^2} = 1 - \frac{\sum_{i=1}^{n}(y_i - f_{(-i)}(x_i))^2}{\sum_{i=1}^{n}(y_i - \overline{y})^2}, \tag{10}$$

where $f_{-i}(x_i)$ represents the value at x_i produced when the best-fit parameters were calculated by leaving out x_i. Cross-validation calculates ϵ_{Q^2} by using Eq. 10 to loop through each measurement for a given data set, leaving out one data point each time, using the remaining data points to determine the best-fit model parameters, and using those best-fit parameters to predict the point left out. ϵ_{Q^2} is predictive because it represents the ratio of predictive variance to total variance.

2.3 Study setup and protocol

Participants were selected from surgical patients at the University of Utah Moran Eye Center. Potential participants were selected by a chart review before surgery. Eligible participants had an adult American Society of Anesthesiologists physical status of I–III and were aged $>$ 18 years. Patients with a baseline SpO2 $\leq$ 93% on room air, surgery scheduled for less than 20 min, ARDS, lung disease, cardiovascular disease, or pregnancy were not eligible to participate.

Before the surgery, participants were fitted with a sampling nasal cannula and the automated system's pulse

oximeter. The sampling line of the nasal cannula was connected to the system's gas analyzer. During the procedure, the automated system administered oxygen at varying flow rates. Each flow rate was administered for 2 min (the time required for measurements to stabilize following a change in flow rate) after which etO2 and SpO2 were recorded by analyzing waveforms collected at 100 Hz by the laptop computer. Given that surgery time would vary between patients, we expected to acquire a different number of paired measurements for each patient. Once the surgery concluded and all paired measurements for a patient were collected, data analysis proceeded as described in Sections 2.1.3 and 2.1.4. Once best-fit parameters had been determined and oxygen saturation estimated, model fit was assessed as described in Section 2.2. For comparison, fit for a model using generic parameter values, $\mathbf{x} = \{26.8, 2.7, 1.0\}$, was also assessed using Eq. 8.

2.4 Statistical analysis

Statistical analysis was performed using Python (v2.7.14, Python Software Foundation, Beaverton, OR). Median $epsilon_{R^2}$ and $epsilon Q^2$ across all patients was calculated. The interquartile range (IQR), including 25th and 75th percentiles, was used to report uncertainty.

Differences between measurements y_i and model output $f(x_i)$ were compared for both descriptive and predictive modeling using limits of agreement (LoA) methods. The absolute difference between measurements y_i and model output $f(x_i)/f_{(-i)}(x_i)$ is the residual and was calculated for all measurements:

$$f(x_i) - y_i \tag{11}$$

$$f_{(-i)}(x_i) - y_i \tag{12}$$

LoA methods calculated the mean difference of all data points using Eqs. 11 or 12. Ninety-five percent LoA were calculated as $\pm$ 1.96 SD where SD is the standard deviation of the difference between all data points. To determine differences between predictive and descriptive modeling, the LoA for descriptive and predictive modeling were compared.

For each patient, an F-test was used to determine if the specific fit improved model fit significantly compared with a standard ODC. The F-statistic F was calculated as:

$$F = \frac{\left(\frac{RSS_{std} - RSS_{spec}}{p_{spec} - p_{std}}\right)}{\left(\frac{RSS_{spec}}{n - p_{spec}}\right)}, \tag{13}$$

where RSS_{std} and RSS_{spec} are the residual sum of squares (RSS) when using the standard and specific curves respectively, $p_{std} = 0$ and $p_{spec} = 3$ are the number of parameters in the standard and specific models respectively, and n is the number of data points. The specific model fit was significantly improved if F calculated using Eq. 13 was greater than the critical value of the F-distribution with $(p_{spec} - p_{std}, n - p_{spec})$ degrees of freedom and $\alpha = 0.05$.

3 Results

Thirty-nine patients participated in this study. A total of 498 data points were evaluated with an average of 12 data points per patient. The mean values as well as standard deviation (SD) and range for P_{50}, n, and K are shown in Table 2. For 19 of the 39 patients, a specific ODC improved model fit significantly ($F > F$-critical).

Figure 2 shows the model fit for a typical patient. The best-fit parameters for this particular patient were $\mathbf{x} = \{24.9, 1.9, 0.99\}$. When performing leave-one-out analysis, the mean $\pm$ SD for the best-fit parameters was $\mathbf{x} = \{25.0 \pm 1.6, 1.9 \pm 0.1, 0.99 \pm 0.001\}$. Using a patient-specific ODC to fit patient data points increased correlation (ϵ_{R^2}, 0.94 vs. -2.36, specific vs. generic) and improved model fit significantly ($F > F$-critical). Leave-one-out analysis also showed increased correlation ($\epsilon_{Q^2} = 0.92$). This patient-specific curve shows how oxygen saturation would begin to drop long before a standard ODC would predict. For example, oxygen saturation at 70 mm Hg for the standard curve is 0.93 while for the patient-specific curve, it is 0.87.

The coefficient of determination ϵ_{R^2} for all patients is shown in Fig. 3. Using patient-specific parameter values resulted in increased correlation compared with standard values (median (IQR) ϵ_{R^2}, 0.42 (0.63) vs. -0.22 (2.08), specific vs. standard). The median difference (specific - standard) in ϵ_{R^2} for paired data was 0.85 with an interquartile range from 0.29 to 1.90. The median absolute difference between modeled data points $f(x_i)$ and observed measurements y_i for all patients was -0.0005 SpO2. The 95% LoA were from -0.0149 to 0.0140 SpO2 (Fig. 4).

The predictive coefficient of determination ϵ_{Q^2} for all patients is shown in Fig. 3. The median (IQR) ϵ_{Q^2} was 0.07 (0.81). The median absolute difference between predicted data points $f_{(-i)}(x_i)$ and observed measurements y_i for all patients was -0.0005 SpO2. The 95% LoA were from -0.0189 to 0.0179 SpO2 (Fig. 4).

Table 2 Mean, variability, and dispersion of optimal values for P_{50}, n, and K

Parameter	Mean (SD)	Range (min.–max.)	Units
P_{50}	32.0 (14.4)	53.4 (15.0–68.4)	mm Hg
n	3.2 (0.8)	2.2 (1.67–3.9)	Unitless
K	1.00 (0.01)	0.06 (0.94–1.00)	Unitless

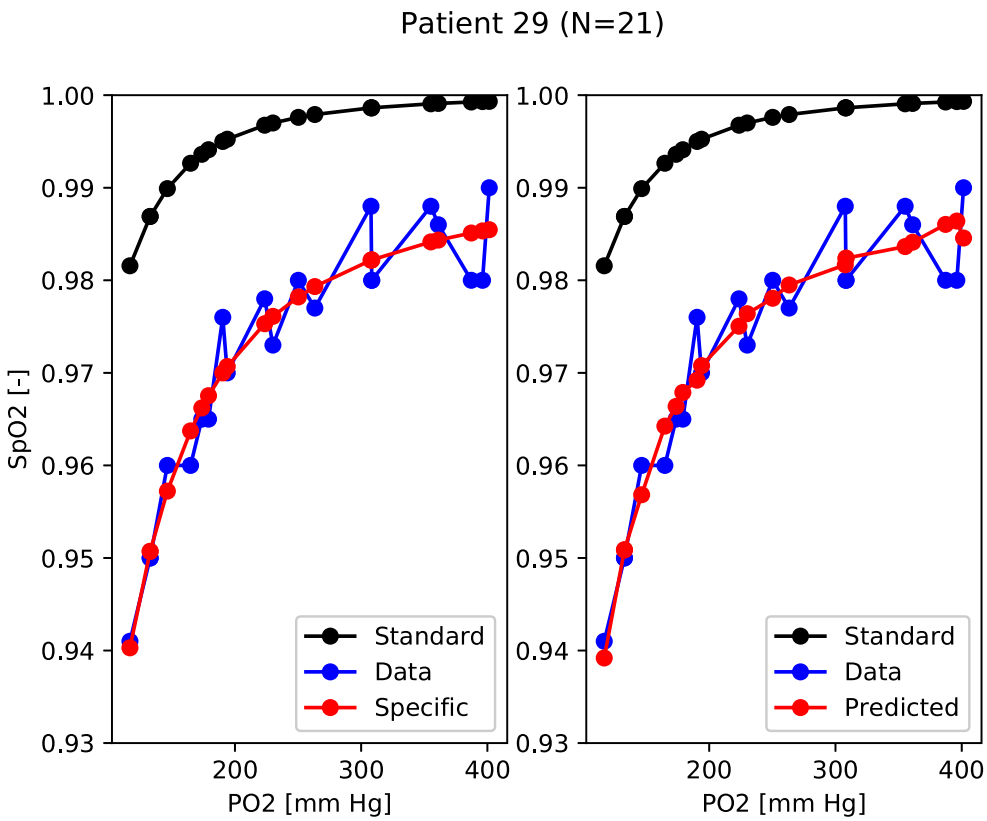

Fig. 2 Model fit and prediction for a selected patient. For this particular patient, the best-fit values were $\mathbf{x} = \{24.9, 1.9, 0.99\}$. Correlation increased when using a specific oxyhemoglobin dissociation curve (ϵ_{R^2}, 0.94 vs. −2.36, specific vs. standard). Leave-one-out analysis also showed increased correlation ($\epsilon_{Q^2} = 0.92$). Here specific refers to an ODC generated using patient-specific measurements and predicted refers to an ODC generated using leave-one-out analysis of those same measurements. Leave-one-out analysis is useful for determining how sensitive the parameters are to errors in the fit

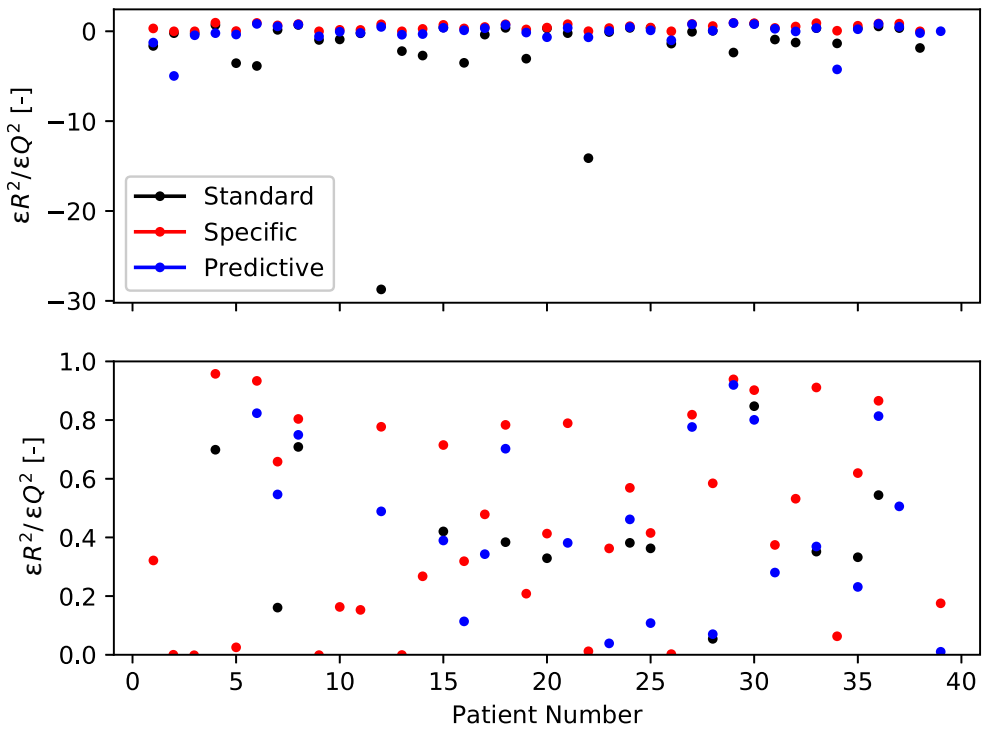

Fig. 3 Coefficient of determination $\epsilon_{R^2}/\epsilon_{Q^2}$ when model parameters are set to standard values compared with when model parameters are set to best-fit values. The upper panel shows an expanded view of all $\epsilon_{R^2}/\epsilon_{Q^2}$ values while the lower panel shows a magnified view centered on the $\epsilon_{R^2}/\epsilon_{Q^2}$ range from 0 to 1. Here specific refers to an ODC generated using patient-specific measurements and predicted refers to an ODC generated using leave-one-out analysis of those same measurements

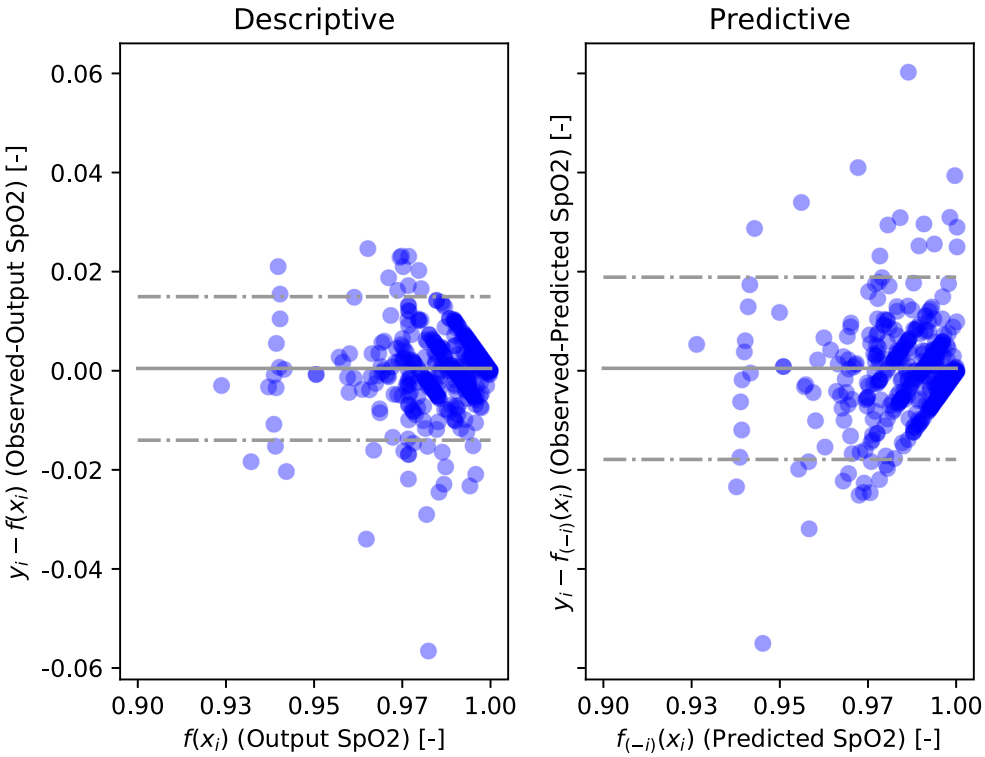

Fig. 4 Bland-Altman analysis for descriptive and predictive modeling. For descriptive modeling (left), the median absolute difference was −0.0005 SpO2 with 95% LoA from −0.0149 to 0.0140 SpO2. For predictive modeling (right), the median absolute difference was −0.0005 SpO2 with 95% LoA from −0.0189 to 0.0179 SpO2

4 Discussion

This manuscript describes a procedure for determining an apparent patient-specific pulse oxygen saturation response. Results have shown that the procedure improved the model fit of patient saturation values significantly ($F > F$-critical) in 19 of 39 patients. Results have also shown that using patient-specific parameter values increases correlation when compared with standard values. The predictive capability of the procedure was also tested, and results show that the LoA when predicting were within ± 0.02 SpO2.

These results demonstrate the ability of the procedure to provide a more accurate estimate of patient oxygen saturation response when compared with using standard parameter values. This accurate estimate could help determine a patient's specific response and thus define the PO2 at which a patient's SpO2 would begin to decline rapidly. Further, this accurate estimate could be used to describe the decline in SpO2 with time.

The procedure improved model fit significantly in only 19 of 39 patients. However, the accuracy of fit in the remaining 20 patients was still increased compared with the standard ODC (although not significantly). This result does not say that the specific fit for the remaining 20 patients was not accurate but rather that using the standard ODC for those 20 patients would be sufficient. This study has provided a general idea of the usefulness of the procedure in its patient population. For this population, basing clinical decision-making on the standard ODC is insufficient for approximately half of patients. Instead, for these patients, determining a specific ODC is necessary for accurately locating relevant portions of their ODC.

Previous related research has studied how accurately SpO2 predicts arterial partial pressure of oxygen (PaO2) [4, 17]. Brockway et al. found that PaO2 correlated significantly with SpO2. This research has added to these results by demonstrating increased correlation when determining patient-specific parameter values.

As expected, the mean best-fit values for model parameters (Table 2) compared well with typical standard values. However, a wide range of parameter values was observed when considering the patient population as a whole. This wide range demonstrates the utility in determining patient-specific parameter values to predict oxygen saturation response.

For some of the parameters, the upper or lower parameter constraint was reached in at least one patient. Two bounds of particular interest for which this occurred were the lower bound of $P50 = 15$ and the upper bound of $n = 3.9$. Had the constraint window for these parameters been broader correlation may have been improved but the parameter value may not have been physiologically realistic. This demonstrates the balance between improved model fit and physiologically realistic results. The proper range

for realistic constraint windows on P50, n, and K should be explored further and considered in future research on oxygen saturation response.

When predicting SpO2, as simulated using leave-one-out cross-validation, this procedure exhibited larger LoA compared with descriptive modeling. This result indicates that the predictive capability of the procedure depends on the number of measurements acquired, with the predictive capability of the procedure increasing with the number of measurements. Therefore, the number of measurements acquired may influence the accuracy of the procedure's predictions and thus the procedure should be used with care when circumstance only allows for only a few paired measurements. However, further research should be conducted to determine the predictive capability of the procedure when using measurements with less error.

Prophylactic administration of supplemental oxygen may impair pulse oximetry's clinical utility [11, 14, 22]. By determining a subject-specific oxygen saturation response, the procedure could be used to individualize oxygen therapy to maintain a target oxygen saturation range. This would enable elevating PO2 to levels required to maintain adequate oxygen saturation, but no higher. Since PO2 levels would not be elevated, pulse oximetry could then indicate hypoventilation earlier. Further, the subject-specific response determined using the procedure could determine whether oxygen administered is even required. If the patient exhibited increased oxygen affinity, this could indicate that oxygen therapy is not required.

The procedure measures two different types of data pairs: central evaluation of the partial pressure of oxygen (etO2) and peripheral evaluation of oxyhemoglobin saturation (SpO2). The peripheral and central chemical and physical conditions of pH, PCO2, [DPG], and T are likely significantly different with some saturation loss peripherally. Hypothetically, this could have resulted in the K estimates that were less than 1.0. If the saturation loss peripherally was 2% then only a maximum peripheral saturation of 98% could be reached regardless of the PO2 value (even though central saturation did reach 100%).

The procedure described here measures etO2 as a non-invasive representation of PaO2. These two measurements have been shown to agree well [24] in healthy patients with minimal alveolar-arterial (A-a) oxygen gradient. However, since the procedure measures etO2, if an excess of oxygen is delivered to the patient, an A-a gradient could be artifactually created despite normal lung function. This would then in turn affect the accuracy of the procedure by lowing the value of K.

The procedure measurements may not yield accurate oxygen saturation response in patient populations with significant A-a gradient such as with lung disease that leads to significant ventilation-perfusion inhomogeneities, and substantial physiological shunt. For these populations, the measurements used for the procedure in this study would not be applicable. Instead oxygen saturation and partial pressure of oxygen measurements acquired by arterial blood gas analysis should be used instead. Conveniently the procedure described here does not require any adjustment to facilitate these type of measurements. These patients could be screened by performing a careful review of the patient's medical history and, if necessary, analyzing one initial pair of corresponding measurements to determine the agreement between non-invasive and arterial blood gas measurements.

4.1 Limitations

One limitation of the procedure is that the lowest SpO2 and PO2 values that can be measured are the subject's values while breathing room air. Lower values cannot be safely obtained and administering oxygen only increases SpO2 and PO2. Thus, when using this procedure in healthy subjects, the apparent ODC is built using data points measured in the hyperoxic range while the data points of most interest are in the hypoxic range. The accuracy of using hyperoxic data to extrapolate and predict hypoxic values in a given patient is unknown.

The procedure measures SpO2 to represent SHbO2. Although SpO2 measurement is less invasive, it has a reported accuracy of $\pm$ 2–3% compared with SHbO2 which introduces measurement uncertainty. This accuracy was unknown and not considered in the present research and may have affected the best-fit parameters, particularly K. The error of the procedure would be underestimated if the statistical error in each single SpO2 measurement was larger than the differences observed between the consecutive levels of PO2. For example, when making SpO2 measurements at adjacent levels of PO2, if the actual SpO2 were 96% and 98% and the accuracy of measurement technique were $\pm$ 2%, then the window of possible reported measurements for each measurement overlaps. In another situation where the pulse oximeter reported a SpO2 of 98% at 100% SHbO2, the procedure may have determined the best-fit value of K to be 0.98. With this in consideration, the accuracy of SpO2 may in part have affected the range of K values observed in this study.

For the study's statistical purposes, repeated measurements were not collected within patients. Because repeated measurements were not made, the reproducibility of the procedure has not yet been assessed. This is an important aspect to consider given that variations in measurement uncertainty with time could affect the accuracy of measurements which will likely generate different patient-specific ODCs. However, during clinical application, the procedure could continuously measure SpO2 and PO2 at different oxygen

levels, generating many more data points than were collected in this study and estimating the mean SpO2 for points measured at the same PO2.

4.2 Future research

Future research studies should extend the experimental protocol to groups featuring significantly different pulse oxygen saturation response to better understand the clinical relevance of the procedure. Extending the protocol would also allow for monitoring the goodness of fit in these groups and provide a better understanding of the generality of the procedure. Extending the protocol is required to demonstrate that the performance of the procedure was not exclusively due to the selection of patients from a healthy population but is also useful in patient populations with various different pulse oxygen saturation responses.

Future directions for this research would be to combine the procedure with existing models [13, 16] to simulate and predict oxygen saturation and time to desaturation in patients with varying levels of respiratory drive. Predicting the course of SpO2 for a given amount of time could help explore and experiment with simulations on different clinical scenarios that may not be safe to study in volunteers or patients.

If this procedure is to be clinically useful, further studies demonstrating its ability to extrapolate and predict the ODC below the patient's normoxic range should be conducted. Non-invasive measurements are used to generate the procedure's apparent ODC. In further study, these patient-specific ODCs should be compared with corresponding ODCs generated using measurements obtained by arterial blood gas analysis.

5 Conclusion

In summary, this paper has demonstrated and tested a procedure for determining patient-specific pulse oxygen saturation response. The procedure was able to determine best-fit parameters that resulted in significantly improved fit when compared with using standard parameter values. These best-fit parameters increased the coefficient of determination ϵR^2 in all cases.

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Compliance with ethical standards

Conflict of interest Kyle Burk: Dynasthetics, LLC and Joseph Orr: Dynasthetics, LLC

Ethical approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable standards.

Informed consent was obtained from all individual participants included in the study.

This article does not contain any studies with animals performed by any of the authors.

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