Effect of Two Different Temperature Settings on Patient Comfort Level during Respiratory Therapy by High-Flow Nasal Cannula

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Abstract

Background Hypoxemic respiratory failure may require high flow O2 therapy (>15 L/m), which can be delivered using a high-flow nasal cannula (HFNC) device. There are three variables: FiO2, flow, and temperature that can be controlled while using HFNC. This study was planned to assess the degree of comfort level of patients at two different temperature settings.

Methods A prospective interventional cross-over study was performed on 40 hypoxemic respiratory failure patients, who were on HFNC. Primary outcome was to assess patient comfort during HFNC therapy at two different temperatures (31 and 37°C), at the flow of 60 L/m for 30 minutes at each temperature setting, leaving FiO2 unchanged. After 30 minutes of each temperature setting, the comfort level was assessed using 11 score visual numerical scale (ranging from 0 to 10) together with other vital parameters.

Result Patients were found to be more comfortable at temperature settings of 31°C than at 37°C (p-value < 0.05%). Also, an increase in blood pressure was observed at 37°C after completion of 30 minutes, which was statistically significant but not clinically significant.

Conclusion Starting HFNC therapy at lower temperature gives better patient acceptance and reduces chances of failure due to discomfort.

Keywords
- high-flow nasal canula
- temperature
- comfort level

Introduction

Oxygen (O2) therapy is the first step to prevent and manage hypoxemic respiratory failure. High flows (>15 L/m),1 such as 30 L/m and 60 L/m can be easily delivered using HFNC. It has shown to have better tolerance and comfort level than conventional devices.2–4

Different parameters of HFNC device (FiO2, flow, and temperature) can be controlled independently. There are studies comparing patient comfort level between NIV and HFNC but there is a need to know the optimal settings of HFNC to achieve adequate patient comfort level. So, we planned this study to compare the degree of patient comfort level at different temperature settings of HFNC.

Materials and Methods

This prospective interventional cross-over study was carried out after patient’s informed written consent, Institutional
Ethics Committee approval, and CTRI registration (CTRI
number- CTRI/2021/07/035224). Confidentiality of subjects
was maintained. The procedures followed were in accor-
dance with the ethical standards of the institutional com-
mittee on human experimentation and with the Helsinki
declaration of 1975, as revised in 2000.
A total of 40 non-sedated patients on HFNC with approp-
riate sized nasal cannula at a flow rate of 60 L/min (as per
the inclusion and exclusion criteria) participated in the
study.
Inclusion criteria–Patients admitted in the ICU with age
between 18 and 65 years on HFNC (Optiflow, Fisher & Paykel
Healthcare, Auckland, New Zealand) Exclusion criteria–
Patients admitted in the ICU with age <18 years and >65
years, hemodynamic instability, altered mental status,
patients on non-invasive ventilation, intubated or tracheos-
tomized, pregnant patients, and febrile or hypothermic
patients
The primary objective of the study was to assess all 40
patients for the degree of comfort using 11 score visual
numerical scale (VNS) ranging from 0 to 10 at the end of
30 minutes, each for two different temperature settings.
Secondary objective was to compare the changes noted in
the vital parameters such as heart rate (HR), systolic blood
pressure (SBP), diastolic blood pressure (DBP), respiratory
rate (RR), and SpO2, at the end of each step.
Group A–temperature setting of 31°C and flow at 60
L/min.
Group B–temperature setting of 37°C and flow at 60
L/min.
Patients were placed in a semi-recumbent position in a
calm environment. Baseline parameters of all non-sedated
patients already on HFNC (Fisher & Paykel Healthcare) who
were on a flow of 60 L/m (as advised by the ICU physician)
were recorded such as HR, SBP, DBP, RR and SpO2. Every
patient included in the study, on HFNC, temperature was set
to 31°C. Patients were allowed to stay calm, by their own self
for duration of 30 minutes. After 30 minutes, vital param-
eters were recorded and VNS score was asked. Temperature
settings were changed to 37°C. Again, patients were left
undisturbed for a period of 30 minutes, following which, com-
fort level and vital parameters were assessed. All data
were recorded by the personnel other than the person who
set the temperature for the HFNC device.

Results
There were no drop outs in the study; comfort level of all
recruited 40 patients could be assessed as proposed in the
study. The data collected are expressed as mean ± standard
deviation (SD) with 95% confidence level. Mean differences
were calculated from readings at 31°C minus 37°C. Paired t-
test was applied to compare the variables. A p-value < 0.05
was considered statistically significant.
As this was a cross-over study, patients allotted in each of
the two groups were same; hence, mean age and sex were
same for the two groups. The mean age was 44.6 ± 2.33 years,
and out of the 40 subjects, 24 were males and 16 females.

Table 1 Results of change in variables at two different
temperatures

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean ± SD</th>
<th>Mean difference</th>
<th>p-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>VNS (31°C)</td>
<td>8.3 ± 0.60</td>
<td>2.9</td>
<td>0.000</td>
</tr>
<tr>
<td>VNS (37°C)</td>
<td>5.4 ± 0.54</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HR (31°C)</td>
<td>84.2 ± 9.88</td>
<td>0.3</td>
<td>0.634</td>
</tr>
<tr>
<td>HR (37°C)</td>
<td>84.5 ± 9.03</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>SBP (31°C)</td>
<td>118.5 ± 9.57</td>
<td>2.0</td>
<td>0.000</td>
</tr>
<tr>
<td>SBP (37°C)</td>
<td>120.5 ± 9.44</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>DBP (31°C)</td>
<td>76.7 ± 8.72</td>
<td>1.5</td>
<td>0.005</td>
</tr>
<tr>
<td>DBP (37°C)</td>
<td>78.3 ± 7.63</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>MAP (31°C)</td>
<td>89.9 ± 8.24</td>
<td>1.8</td>
<td>0.000</td>
</tr>
<tr>
<td>MAP (37°C)</td>
<td>91.8 ± 7.92</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>SpO2 (31°C)</td>
<td>97.8 ± 0.81</td>
<td>0.025</td>
<td>0.830</td>
</tr>
<tr>
<td>SpO2 (37°C)</td>
<td>97.8 ± 0.66</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RR (31°C)</td>
<td>20.0 ± 1.42</td>
<td>0.175</td>
<td>0.484</td>
</tr>
<tr>
<td>RR (37°C)</td>
<td>19.9 ± 1.19</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1Abbreviations: DBP, diastolic blood pressure; HR, heart rate; MAP,
mean arterial blood pressure; RR, respiratory rate; SpO2, oxygen
saturation; SBP, systolic blood pressure; SD, standard deviation; VNS,
visual numeric scale.
2Temperature at which reading is noted in brackets.
3Mean differences were calculated from readings at temperature of 31°
C minus 37°C.

Comfort level–Patients were found to be more comfort-
able in group A in comparison to those in group B with a
mean difference of 2.9 VNS at two temperatures (p < 0.05),
which was clinically as well as statistically significant
(►Table 1, ▶Fig. 1).
Vital signs–Group B showed an increase in SBP, DBP, and
MAP after completion of 30 minutes as compared to group A
(p < 0.05), which was statistically significant although mean
differences were not that profound, showing no clinical
significance (►Table 1, ▶Figs. 2–4).
Other variables such as HR, SpO2, and RR were not
clinically as well as statistically significant (p > 0.05)
(►Table 1, ▶Figs. 5–7).

Discussion
Earlier O2 therapy in spontaneously breathing patients were
possible by nasal prongs and facemasks, which work well at
flows of up to 10 L/m. High-flow O2 therapy (>15 L/m) may
lead to drying of nasal mucosa even with bubble humidifi-
cation due to air entrainment. Higher flows of totally condi-
tioned gas (37°C containing 44 mg H2O/l (100% relative
humidity)1 such as 30 L/m and 60 L/m can be delivered
using HFNC.1 It prevents drying of mucosa, having a protec-
tive effect on mucus-ciliary function such as secretion clear-
ance and airway defense.
Also, gas conditioning may decrease inflammation of the
tracheal mucosa after intubation; hence, the use of HFNC
prior to extubation, prevents the administration of dry and
cold air in the native airway of the patients, causing fewer
reintubations secondary to upper airway obstruction and
also, accelerated weaning in tracheostomized persons.2,5
**Fig. 1** Visual numeric scale at 31°C and 37°C.

**Fig. 2** Systolic blood pressure at 31°C and 37°C.

**Fig. 3** Diastolic blood pressure at 31°C and 37°C.
**Fig. 4** Mean arterial pressure at 31°C and 37°C.

**Fig. 5** Heart rate at 31°C and 37°C.

**Fig. 6** Oxygen saturation at 31°C and 37°C.
Many studies have shown oxygenation enhancement and reduction in the respiratory rate by early application of HFNC compared to standard oxygen therapy.\(^2\)\(^-\)\(^4\) It has shown positive clinical impact on patients with acute hypoxemic respiratory failure.\(^5\)\(^-\)\(^8\) HFNC has better tolerance and comfort than non-invasive ventilation (NIV).\(^9\)\(^,\)\(^10\) HFNC reduces intubation rate, increasing ventilator-free days, and reduced 90-day mortality. However, the rate of intubation in patients on HFNC and NIV were found to be similar in many studies\(^11\)\(^-\)\(^13\) with studies showing better oxygenation with NIV.\(^9\)\(^,\)\(^10\)

Better comfort levels help in improving the tolerance for any undergoing procedure. Recently, FLORALI study (post hoc analysis) showed intubation within 1 hour of starting HFNC due to discomfort, suggesting a strong link between discomfort and poor outcomes.\(^14\) Comfort level is a patient-level outcome generated on the basis of various physiologic mechanisms.\(^15\)\(^,\)\(^16\) Various physiological studies have been conducted before to measure comfort level in patients on non-invasive respiratory support, scale used was the same as in this study, i.e., VNS.\(^17\)\(^-\)\(^19\)

In this study, patients were found to be more comfortable at lower temperature of 31°C than 37°C at 60 L/min of flow of HFNC. Marginal rise in SBP, DBP, and MAP was observed at higher temperatures, which was statistically significant but not clinically significant.

Comfort level is higher at lower temperatures and may suggest negative psychosomatic and physiologic signals such as excessive heating of nostrils in spite of the advantage of maximum humidity.\(^17\) However, because the heating and moisturizing function of the upper airway is preserved during use of the HFNC, starting HFNC at lower temperatures and gradually increasing it with time may be a considered, it may lead to better clinical outcomes such as better tolerance, longer duration of HFNC application, and improved comfort. Patients showed different comfort levels at different temperatures, may point toward personalizing the settings on individual basis rather than using fixed standard settings.\(^20\)

Certain limitations pertinent to study are: firstly, our primary aim was subjective psychological outcome. Comfort level according to the temperature may be variable, and differ on person to person basis. Secondly, observation time in our study is limited to 30 minutes. Patient may show discomfort in a longer time of surveillance. Thirdly, ventilator settings including FiO\(_2\) were not considered in baseline comparisons, which may affect comfort levels. Fourthly, midway settings such as 34°C were not assessed, only extreme values were considered. Fifthly, larger studies with bigger sample size may validate our findings.

**Conclusion**

Starting HFNC therapy at lower temperature gives better patient acceptance and reduces chances of failure due to discomfort. Gradually temperature may be increased or adjusted on personalized basis according to the patients comfort. To use comfort level as a guide to HFNC settings as a non-invasive respiratory support, larger studies are needed for its validation.

**Authors’ Contributions**

Dr. Mamta Kumari– concept, design, literature search.

Dr. Megha Soni– data acquisition, literature search.

Dr. Niharika Grover–literature search, definition of intellectual content, manuscript preparation.

Dr. Rashmi Taneja –manuscript editing and review.

Dr. Mamta Kumari is the guarantor and takes the responsibility for the integrity of work as a whole from inception to published article.

**Declaration**

This manuscript has been read and approved by all the authors, requirements for authorship have been met, and each author believes that the manuscript presents the honest work. Article is not published nor under
consideration, in part or whole simultaneously in any other journal or any other proceedings.

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**Conflicts of Interest**

None declared.

**References**