Are Aneroid Sphygmomanometers Accurate in Hospital and Clinic Settings?

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Background: The aneroid sphygmomanometer is commonly used for the indirect measurement of blood pressure despite significant concerns about its accuracy. Although the mercury sphygmomanometer is highly accurate, there are concerns about the environmental toxicity of mercury. In response to various external pressures to become essentially mercury free, the Mayo Clinic, Rochester, Minn, has replaced many mercury sphygmomanometers with aneroid devices. Since 1993, a maintenance protocol has been in place to ensure proper function and accuracy of these devices.

Methods: We assessed the accuracy of 283 aneroid devices using as the reference standard a digital pressure and vacuum meter that was calibrated using a mercury sphygmomanometer.

Results: The mean ± SD values from the aneroid device in millimeters of mercury at each reference point (at 20–mm Hg intervals from 60 to 240 mm Hg defined by the reference device) were 59.9 ± 1.9 at 60; 79.9 ± 1.9 at 80; 100.0 ± 1.8 at 100; 120.3 ± 1.4 at 120; 140.7 ± 1.4 at 140; 160.7 ± 1.7 at 160; 180.9 ± 1.3 at 180; 200.7 ± 5.0 at 200; 221.0 ± 1.3 at 220; and 240.8 ± 1.6 at 240 (r = 0.99; P < .001). The values from the aneroid device underestimated those of the reference device by a mean of 0.5 mm Hg (95% confidence interval, 0.3-0.7). Virtually 100% of the values from the aneroid device were within the 4–mm Hg range recommended by the Association for the Advancement of Medical Instrumentation.

Conclusion: Aneroid sphygmomanometers provide accurate pressure measurements when a proper maintenance protocol is followed.

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METHODS

Since 1993, approximately 1500 mercury sphygmomanometers were replaced with wall-mounted aneroid devices at the 2 principal inpatient areas of the Mayo Clinic (Saint Marys Hospital and Rochester Methodist Hospital), Rochester, Minn. At the same time, the following protocol was developed in conjunction with the Division of Hypertension and in accordance with the standards published by the Association for the Advancement of Medical Instrumentation. This protocol was incorporated into an annual inspection of additional patient-related medical devices in all patient care areas, including medical and surgical nursing units, critical care units, surgical units, and radiology procedure areas. The protocol was performed by a biomedical equipment maintenance technician following instruction and initial observation by a member of the Division of Hypertension (P.L.J.).

PROTOCOL

1. All aneroid devices were visually inspected for damage to the instrument case, wall mount, bracket, and extension hose.
2. The sphygmomanometer needle should be set to zero prior to inflation.
3. A digital pressure and vacuum meter (Digi- manometer, Netech Corp, Hicksville, NY) was used as the reference standard. This device was checked for accuracy against a mercury sphygmomanometer twice yearly by the biomedical equipment maintenance technician and was also checked by the manufacturer once yearly. When checked for accuracy against a mercury sphygmomanometer set to zero throughout the pressure range of 60 to 240 mm Hg, the digital reference device underestimated the former by 0.12 mm Hg (95% confidence interval, 0.00-0.24). Subsequently, a Y tube was used to connect the inflation bulb to the reference and aneroid devices. The tube was then inflated to 240 mm Hg on the reference device and the corresponding value on the aneroid device was 59.9±1.9 at 60; 79.9±1.9 at 80; 100.0±1.8 at 100; 120.3±1.8 at 120; 140.7±1.4 at 140; 160.7±1.7 at 160; 180.9±1.3 at 180; 200.7±5.0 at 200; 221.0±1.3 at 220; and 240.8±1.6 at 240. The values from the aneroid device were virtually identical in the intervals between 60 mm Hg and 240 mm Hg (r=0.99; P<.001). The values from the aneroid device underestimated those of the reference device by a mean of 0.5 mm Hg (95% confidence interval, 0.3-0.7). Virtually 100% of the values from the aneroid device were within 4 mm Hg of the reference device (Figure).

The results of this study demonstrate that aneroid sphygmomanometers provide accurate pressure determinations when compared with a digital pressure and vacuum meter. The performance of the aneroid sphygmomanometers was well within the accuracy guidelines of 3 to 4 mm Hg as recommended by several authors. This finding contradicts the results of several previous studies. The contribution of a routine maintenance regimen in assuring accuracy of aneroid sphygmomanometers is suggested by better performance of the inpatient devices compared with the outpatient devices that were not part of the maintenance protocol (1 of 248 inpatient devices were replaced vs 3 of 35 outpatient devices replaced). A potential strength of this study is that the data were collected as part of an ongoing maintenance program and were not a random prospective sample that could have been biased by the inclusion or exclusion of recently inspected aneroid devices.

Routine maintenance of sphygmomanometers may not be widespread. In a survey conducted in general practitioners in England, only about 50% had serviced their
devices within 1 year and 24% of devices had never been serviced (over a mean of 6 years). While the present study was limited to the evaluation of fixed, wall-mounted aneroid sphygmomanometers, there is no a priori reason to suspect that a similar maintenance protocol could not apply to more portable devices, such as those that are handheld or attached to the blood pressure cuff. Indeed, these latter devices are more susceptible to damage from everyday use and are more likely to need periodic inspection.

The mercury column sphygmomanometer has remained the gold standard of indirect blood pressure measurement for many years. In our experience and we suspect in that of most clinicians, it has provided trouble-free service, other than the occasional need for calibration and replacement of worn tubing or cuffs. Unfortunately, the potential environmental toxicity of mercury, whether real or imagined, has led to increased interest in mercury-independent measurement of blood pressure. We were somewhat surprised when we reviewed the Mayo Clinic experience with mercury spills from October 1, 1993, to November 30, 1995. During this time, 50 spills were documented related to leakage from sphygmomanometers. Several of these spills resulted from physical abuse to the device by unruly patients, children, or patients with dementia or other psychiatric problems. The cleanup costs were $260,000, not including time lost from temporary unavailability of the clinical area. Use of a digital pressure and vacuum meter as a reference device by unruly patients, children, or patients with dementia has provided trouble-free service, other than the occasional need for calibration and replacement of worn tubing or cuffs.

In conclusion, a carefully maintained aneroid sphygmomanometer is an accurate and clinically useful means of indirect blood pressure measurement.

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