A prolonged postinspiratory pause enhances CO2 elimination by reducing airway dead space.

Uttman, Leif; Jonson, Björn

Published in:
Clinical Physiology and Functional Imaging

DOI:
10.1046/j.1475-097X.2003.00498.x

2003

Link to publication

Citation for published version (APA):

Total number of authors:
2

General rights
Unless other specific re-use rights are stated the following general rights apply:
Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.
• Users may download and print one copy of any publication from the public portal for the purpose of private study or research.
• You may not further distribute the material or use it for any profit-making activity or commercial gain
• You may freely distribute the URL identifying the publication in the public portal
Read more about Creative commons licenses: https://creativecommons.org/licenses/

Take down policy
If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.
A prolonged postinspiratory pause enhances CO₂ elimination by reducing airway dead space
Leif Uttman and Björn Jonson
Department of Clinical Physiology, University Hospital, Lund, Sweden

Correspondence
Leif Uttman, Department of Clinical Physiology, University Hospital, SE-221 85 Lund, Sweden
E-mail: leif.uttman@klinfys.lu.se

Accepted for publication
Received 22 November 2002; accepted 18 February 2003

Key words
artificial respiration; breath tests; capnography; pulmonary gas exchange; swine

Background: CO₂ elimination per breath (V_{CO₂,T}) depends primarily on tidal volume (V_T). The time course of flow during inspiration influences distribution and diffusive mixing of V_T and is therefore a secondary factor determining gas exchange. To study the effect of a postinspiratory pause we defined ‘mean distribution time’ (MDT) as the mean time given to inspired gas for distribution and diffusive mixing within the lungs. The objective was to quantify changes in airway dead space (V_{Daw}), slope of the alveolar plateau (SLOPE) and V_{CO₂,T} as a function of MDT in healthy pigs.

Methods: Ten healthy pigs were mechanically ventilated. Airway pressure, flow and partial pressure of CO₂ were recorded during resetting of the postinspiratory pause from 10% (baseline) to, in random order, 0, 5, 20 and 30% of the respiratory cycle. The immediate changes in V_{Daw}, SLOPE, V_{CO₂,T} and MDT after resetting were analyzed.

Results: V_{Daw} in percent of V_T decreased from 29 to 22%, SLOPE from 0.35 to 0.16 kPa per 100 ml as MDT increased from 0.51 to 1.39 s. Over the same MDT range, V_{CO₂,T} increased by 10%. All these changes were statistically significant.

Conclusion: MDT allows comparison of different patterns of inspiration on V_{Daw} and gas exchange. Estimation of the effects of an altered ventilator setting on exchange of CO₂ can be done only after about 30 minutes, while the transient changes in V_{CO₂,T} may give immediate information. MDT affects gas exchange to an important extent. Further studies in human subjects in health and in disease are needed.

Introduction
A low tidal volume (V_T) appears to be a crucial factor for lung protective ventilation in the acute respiratory distress syndrome. When low V_T is used to provide lung protective ventilation, respiratory acidosis can be partly balanced by an increased respiratory rate (RR) (ARDS Network, 2000). In itself, a low V_T leads to increased dead space fraction. A short duration of inspiration that follows from an increased RR may then further compromise gas exchange by uneven distribution and inadequate mixing of V_T in the alveolar space. Different means to reduce dead space have been suggested. For instance, replacement of passive humidifiers with active ones, tracheal gas insufflation and aspiration of dead space implies that the interface between ‘fresh and old’ gas is moved distally already at the beginning of inspiration (Jonson et al., 1990; De Robertis et al., 1999; Richercoeur et al., 1999). Furthermore, a ventilator setting that facilitates diffusion may reduce dead space by allowing this interface to move proximally before the end of inspiration. Accordingly, the dead space related to the airways represents function as well as anatomy. Rather than the term ‘anatomical dead space’ we prefer the term airway dead space that should be read as ‘functional airway dead space’. Several studies in health or in disease show a decrease in dead space or PaCO₂ when using a postinspiratory pause (Fuleihan et al., 1976; Dammann et al., 1978; Lachmann et al., 1982; Wolff et al., 1989a; Mercat et al., 2001). However, positive effects of inspiratory patterns intended to improve gas exchange have not always been observed (Johansson, 1975; Johansson & Lofström, 1975; Dammann et al., 1978; Al-Saady & Bennett, 1985; Markstrom et al., 2000). Partly diverging results may reflect methodological limitations. Recently, a known method allowing high accuracy of dead space determination in intensive care was further refined (Beydon et al., 2002). A method to compensate for inevitable changes in V_T can be based on mathematical modelling of the alveolar plateau in the single breath test for CO₂ (SBT-CO₂) (Uttman & Jonson, 2002). In the present study, we introduce the term ‘mean distribution time’.
(MDT), which is the mean time given to inspired gas for distribution and diffusive mixing within the lungs. MDT was varied by changing the duration of the postinspiratory pause at volume controlled ventilation with constant flow. The objective was to quantify changes in airway dead space (V_Daw), slope of the alveolar plateau (SLOPE) and CO₂ elimination per breath (V_CO₂,T) as a function of MDT in healthy pigs.

**Methods**

**Materials**

The local Ethics Board of Animal Research approved the experimental protocol. Ten pigs of the Swedish native breed, mean weight 29-5 kg (23-0–33-5), were fasted overnight with free access to water. Seven of these animals were the same as in (Uttman & Jonson, 2002). The animals were premedicated with azaperon (7 mg kg⁻¹), anaesthetized with ketamin (5 mg kg⁻¹), intubated with a 7-0 mm ID tracheal tube and connected to a ventilator (ServoVentilator 900C, Siemens-Elema, Solna, Sweden). Ventilation was volume controlled with a square inspiratory flow pattern. At baseline setting RR was 20 min⁻¹, inspiratory time 33%, postinspiratory pause time (T_p) 10% and positive end-expiratory pressure 6 cm H₂O. The baseline minute ventilation was adjusted to achieve PaCO₂ 4-5–5 kPa. A mainstream analyzer (CO₂ Analyzer 930, Siemens-Elema, Solna, Sweden) measured partial pressure of CO₂ in expired and inspired gas (P_CO₂). Anaesthesia was maintained by continuous infusion of ketamin (17 mg kg⁻¹ h⁻¹), midazolam (1-7 mg kg⁻¹ h⁻¹) and pancuronium bromide (0-5 mg kg⁻¹ h⁻¹). The ventilator/computer system used for data recording has previously been described (Svantesson et al., 1997). Signals from the ventilator and CO₂ analyzer registering flow rate, airway pressure and P_CO₂ were sampled by a personal computer at the frequency of 50 Hz. Compliance of the tracheal tube and ventilator tubing was measured in vitro. There were no dropouts among the animals.

**Protocol**

After preparation of the animals a stabilization period of 30 min was allowed. A recruitment manoeuvre was performed by inflating the lungs with a pressure of 35 cm H₂O for 10 s to eliminate atelectasis and standardize lung volume history and conditions among the animals. The system was tested for leakage. A continuous record of a study sequence comprised the following elements: 10 normal breaths, 20 breaths of a different T_p, 10 normal breaths. T_p was changed by manual switch of the T_p control of the ventilator from 10 to 0, 5, 20 and 30% of the respiratory cycle, in randomized order.

**Data analysis**

Data sampled during a study sequence were transferred to a spreadsheet for analysis (Excel 97, Microsoft Corp., WA, USA). Measured flow rate was corrected for the compliance in the tubing in order to obtain airway flow rate (V_aw). The expiratory flow signal was normalized by a correction factor so that expired volume equaled inspired volume. The correction factor obtained at T_p 10% was applied to all recordings. V_T was calculated by integration of expired V_aw. Airway dead space distal to the CO₂ sensor was determined according to an algorithm of (Wolff & Brunner, 1984) that was modified to correct for a sloping alveolar plateau (Åström et al., 2000) in accordance with principles previously described (Wolff et al., 1989b). Airway dead space distal to the tip of the tracheal tube (V_Daw) was calculated by subtracting the dead space volume of the tracheal tube and CO₂ analyzer (16 ml). V_CO₂,T was calculated as the difference between expired volume of CO₂ and that re-inspired from the Y-piece and adjacent tubing, which corresponds to the area within the SBT-CO₂ loop (Fig. 1) (Uttman & Jonson, 2002). From an equation describing the alveolar plateau its SLOPE was calculated at the volume halfway between V_Daw and V_T (Beydon et al., 2002). Technical limitations and flux of gas from tubing to the subject in the first phase of a postinspiratory pause caused small variations in V_T and thereby in V_CO₂,T. The effect on V_CO₂,T caused by V_T variation was not an issue of this study and was accordingly corrected for. How V_CO₂,T varies with V_T can be determined from the end-tidal alveolar slope and end-tidal P_CO₂ in the SBT-CO₂ (Uttman & Jonson, 2002). V_CO₂,T was normalized to the lowest V_T observed as was end-tidal P_CO₂.

For a certain pattern of inspiration including the postinspiratory pause, MDT was calculated from all samples during a recorded inspiration as:

\[
MDT = \frac{\sum (V_{aw} \cdot \Delta t \cdot \Delta t_{dist})}{\sum (V_{aw} \cdot \Delta t)}
\]

where \(\Delta t\) is the sampling interval (0.02 s) and \(\Delta t_{dist}\) is the time left for distribution of the particular gas sample until start of expiration.

**Figure 1** The single breath test for CO₂ in a representative animal at different mean distribution time (MDT). Longer MDT resulted in a left-hand shift of the sharp ascending expiratory limb of the loop. This corresponds to a decrease in airway dead space and an increase in tidal CO₂ elimination (area A). The slope of the alveolar plateau decreased with MDT.
Table 1  Consequences of postinspiratory pause.

<table>
<thead>
<tr>
<th>$T_p$ (%)</th>
<th>MDT (s) mean ± SD</th>
<th>$V_{Daw}$ (% of $V_T$) mean ± SEM</th>
<th>$V_{CO,T}$ (ml) mean ± SEM</th>
<th>SLOPE (kPa per 100 ml) mean ± SEM</th>
<th>$P_{CO,ET}$ (kPa) mean ± SEM</th>
<th>$P_{plateau}$ (cm H$_2$O) mean ± SEM</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0.51 ± 0.01</td>
<td>29 ± 1.0</td>
<td>8.0 ± 0.57</td>
<td>0.35 ± 0.04</td>
<td>4.8 ± 0.12</td>
<td>—</td>
</tr>
<tr>
<td>5</td>
<td>0.63 ± 0.01</td>
<td>27 ± 0.9</td>
<td>8.1 ± 0.56</td>
<td>0.26 ± 0.02</td>
<td>4.7 ± 0.13</td>
<td>15.1 ± 0.5</td>
</tr>
<tr>
<td>10</td>
<td>0.78 ± 0.01</td>
<td>25 ± 0.9</td>
<td>8.3 ± 0.59</td>
<td>0.24 ± 0.03</td>
<td>4.7 ± 0.12</td>
<td>14.7 ± 0.5</td>
</tr>
<tr>
<td>20</td>
<td>1.08 ± 0.02</td>
<td>24 ± 0.9</td>
<td>8.6 ± 0.60</td>
<td>0.14 ± 0.01</td>
<td>4.7 ± 0.12</td>
<td>14.7 ± 0.5</td>
</tr>
<tr>
<td>30</td>
<td>1.39 ± 0.02</td>
<td>22 ± 0.8</td>
<td>8.8 ± 0.60</td>
<td>0.16 ± 0.02</td>
<td>4.7 ± 0.14</td>
<td>15.0 ± 0.5</td>
</tr>
</tbody>
</table>

MDT, mean distribution time; $V_{Daw}$, airway dead space; $V_{CO,T}$, tidal CO$_2$ elimination; $P_{CO,ET}$, end-tidal P$_{CO_2}$; $P_{plateau}$, postinspiratory plateau pressure.

**Statistical methods**

Data are presented as mean ± SD. Two-way ANOVA was used to study variations of different parameters with MDT. Student’s paired two-tailed t-test was used to analyze differences among parameters observed at MDT 0.51 s ($T_p$ 0%) and other values of MDT. Non-linear regression was used to establish the relationship between $V_{CO,T}$ and MDT.

**Results**

$V_T$ was 286 ± 42 ml, corresponding to 9.7 ± 1.0 ml kg$^{-1}$. $V_T$ increased with on average 4 ml when $T_p$ increased from 0 to 5% and remained at that level longer at $T_p$. The end-expiratory flow was 0 at $T_p$ 0% to $T_p$ 20% and increased to 0.05 ± 0.04 l s$^{-1}$ at $T_p$ 30%. Plateau pressure measured at the end of the postinspiratory pause showed only minor variations with $T_p$ (Table 1). For the different $T_p$ MDT varied from 0.51 to 1.39 s with a coefficient of variation between animals of less than 2% (Table 1). Figure 1 shows the SBT-CO$_2$ for the different MDT in a representative animal. As appears from Fig. 2, $V_{Daw}$ decreases non-linearly with MDT in each animal. The decrease in $V_{Daw}$ resulted in an increase in $V_{CO,T}$ as illustrated in Fig. 1.

Longer MDT led to lower SLOPE and lower end-tidal P$_{CO_2}$ (ANOVA, P<0.001 for both) (Table 1). Effects on $V_{CO,T}$, related to changes of the alveolar plateau, were calculated from changes in the area below the alveolar plateau. When $T_p$ increased from 0 to 30%, the observed changes of the alveolar plateau did not influence $V_{CO,T}$ ($P>0.05$).

When $T_p$ increased from 0 to 30%, implying that MDT changed from 0.51 to 1.39 s, $V_{CO,T}$ in percent of the value at $T_p$ 0% increased as shown in Fig. 3. The change in $V_{CO,T}$ ($\Delta V_{CO,T}$) was expressed according as follows:

$$\Delta V_{CO,T} = 7.24 + 10.6 \ln(MDT) \ (r = 0.86, P<0.001) \ (2)$$

**Discussion**

At volume controlled ventilation with constant inspiratory flow, this study shows that a postinspiratory pause enhances CO$_2$ elimination by reducing $V_{Daw}$. The uniform results indicate that it is possible to detect even modest changes in $V_{Daw}$ and CO$_2$ elimination. These changes follow immediately after resetting. In contrast, stabilization of PaCO$_2$ following a change in CO$_2$
elimination takes several minutes (Farhi & Rahn, 1955; Taskar et al., 1995) and may be obscured by physiological instability. The determination of MDT according to Eq. (1) was robust as indicated by low scatter (Table 1).

As this study has its focus on methodological and conceptual development it has several limitations. Healthy pigs do not have collateral ventilation (Woolcock & Macklem, 1971). Furthermore, as airway resistance is low, different lung units probably fill and empty nearly synchronously. Obviously, the results cannot be applied on humans in whom collateral ventilation may equilibrate ventilation non-homogeneity. This may be particularly important in obstructive lung disease.

The end-expiratory flow indicated the presence of auto-PEEP at Tp 30%. An estimate based on previous observations of expiratory resistance in healthy pigs (Uttman & Jonson, 2002) suggests that auto-PEEP was less than 0.5 cm H2O. That auto-PEEP was unimportant was further supported by the nearly constant postinspiratory plateau pressure (Table 1). If benefits of a prolonged MDT are obtained by prolongation of inspiration at the expense of expiratory time, a deleterious degree of auto-PEEP may result, particularly in the presence of airway obstruction. A more favourable approach may then be to prolong MDT by changing the flow wave pattern of inspiration. However, we only studied constant inspiratory flow. Pressure controlled ventilation, which particularly in Scandinavia is frequently used, results in a decelerating inspiratory flow. When airway resistance varies within the lung such a flow rate leads to a more even ventilation (Jansson & Jonson, 1972). One rational of decelerating flow is, indeed, to prolong MDT and to promote even gas distribution and diffusion. Obviously, the limitations of this study merit further studies with different flow patterns in humans with different nature of lung pathology.

MDT was conceived with the prospect that it is applicable to all patterns of inspiration. The algorithm of MDT (Eq. 1) dictates that any symmetrical inspiratory waveform will have the same MDT, provided that inspiratory time is constant. The validity of this assumption is supported by that ventilation with square and sine inspiratory waveforms give rise to the same CO2 elimination reflected by equal PaCO2 (Dammann et al., 1978). Notably, a decelerating or accelerating inspiratory flow pattern will have longer and shorter MDT, respectively, compared to symmetrical flow waveforms. Different waveforms have been studied in humans with indistinct results (Johansson, 1975; Johansson & Löfström, 1975; Dammann et al., 1978; Al-Saady & Bennett, 1985; Markström et al., 2000). Such studies merit to be repeated with modern technique.

The effect of a longer Tp on VDaw indicates a movement in the proximal direction of the ‘distal boundary of dead space’ (Bowes et al., 1985). As the total airway cross-section area decreases rapidly with each bronchial generation in the cranial direction (Weibel, 1963), the rate of this movement must be expected to decline in a non-linear fashion, as was found (Fig. 2). The rational of using a logarithmic equation is based on this concept. When MDT is falling towards zero no time is available for diffusion, which is a prerequisite for exchange of gas within the respiratory zone. On the other hand, after a long time for gas distribution the interface between alveolar gas and fresh gas would by diffusion have reached a level in the airways at which the fast drop in total cross-section area would render diffusion more and more inefficient.

The variation in VDaw we observed corresponds to about 0.7 ml kg−1 body weight, which is not trivial with respect to lung protective strategies. In the clinic, it might be desirable to use high RR. If we allow ourselves to extrapolate MDT to 0.25 s (RR 40, Tp 0%), as shown in Fig. 3, VCO2,T would in comparison to MDT 0.51 drop by about 7% and further increase dead space. This would enhance problems related to hypercapnia when Vr is restricted to 6 ml kg−1 (ARDS Network, 2000).

The effect of a longer Tp on SLOPE implies a more even Pco2 in lung units, which empty non-synchronously. This can either be due to equilibration between parallel units caused by pendelluft or by equilibration along longitudinally oriented units in terms of distal and more proximal alveoli (Fletcher, 1980). In principle, one cannot from external global observations differentiate between these models (West, 1971). One can only speculate that low peripheral resistance in healthy pigs might prevent significant uneven ventilation between parallel lung units. Time-dependent equilibration between proximal and more distal alveoli offers a more likely explanation. Anyway, the more even alveolar concentration reflected by a lower SLOPE after a long Tp was not so important so as to significantly reduce VCO2,T.

Our results agree with previous findings that a postinspiratory pause enhances CO2 elimination (Fuleihan et al., 1976; Dammann et al., 1978; Lachmann et al., 1982; Wolff et al., 1989a; Mercat et al., 2001). In the present study, we used the shortest possible tubing (compliance 0.45 ml per cm H2O). In spite of that, about 4 ml was re-distributed from the tubing to the lungs when a postinspiratory pause was applied. If we had not corrected VCO2,T for the increase in Vr, effects of a postinspiratory pause in itself would have been overestimated. In the clinic, both longer tubing and a larger drop in airway pressure at transition to the pause may cause larger Vr variation. In comparison to previous studies, the methodological development is considered to increase the validity and accuracy of the results, which increased the ability to quantify changes in dead space related to modest changes in MDT.

In conclusion, the concept MDT was introduced to allow comparison of different patterns of inspiration with respect to VDaw and gas exchange. Estimation of the effects of an altered ventilator setting on exchange of CO2 can be done after about 30 min, while the transient changes in VCO2,T may give immediate information. MDT affects gas exchange to such an extent that it may be of importance for optimisation of ventilator setting. Further studies on human subjects in health and in disease are needed.

Acknowledgments

This study was supported by the Swedish Research Council (02872) and the Swedish Heart–Lung Foundation. We
acknowledge the contribution of Dr Lars Nordström (†2001) for his inspiration and unpublished ideas behind the concept of MDT.

References


Dammann JF, Mcauslan TC, Maffeo, CJ. Optimal flow pattern for mechanical ventilation of the lungs. 2. The effect of a sine versus square wave flow pattern with and without an end-inspiratory pause on patients. Crit Care Med (1978); 6: 293–310.


Farhi LE, Rahn H. Gas stores of the body and the unsteady state. J Appl Physiol (1955); 7: 472–484.


