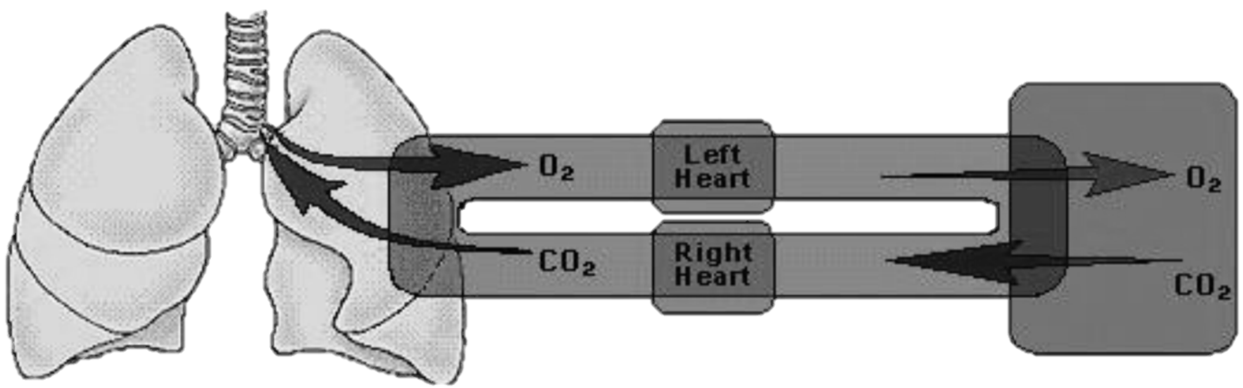
Respiratory Physiology

賴亮全

基礎醫學大樓10樓1009室

分機:88241

E-mail: llai@ntu.edu.tw



為什麼要學呼吸生理學?
不知道這個也活得好好的

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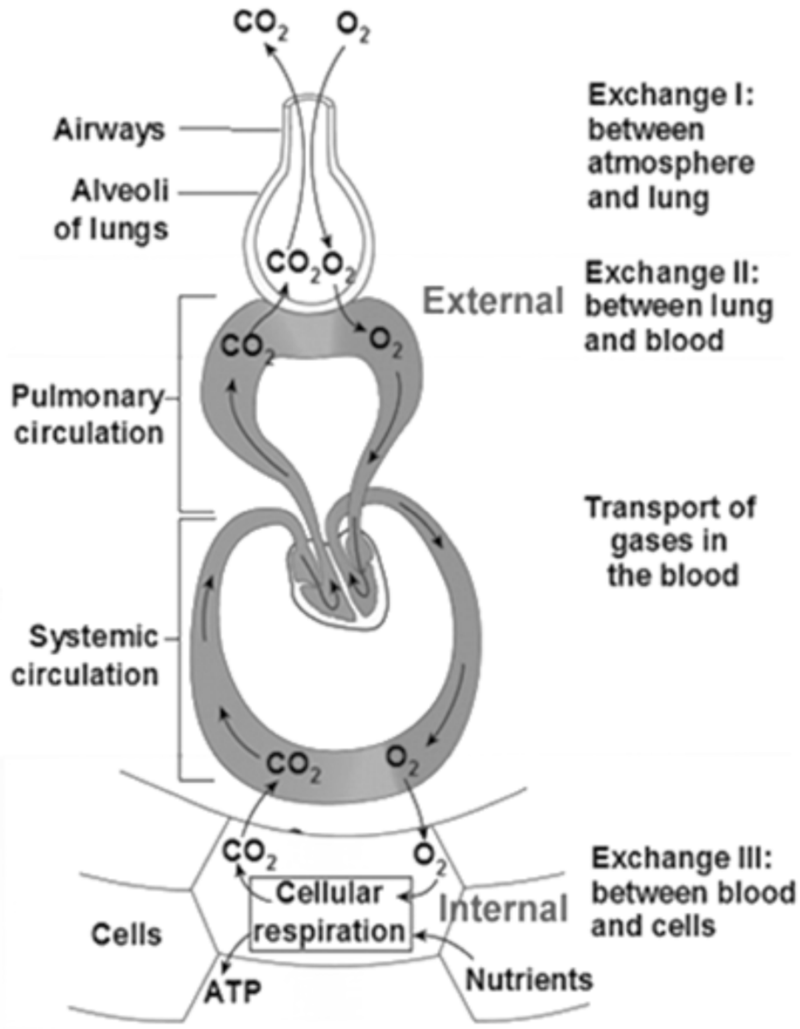
何時需刻意地增加呼吸效率?

- 正常休息
  ✓延腦，不需要特別注意
- 周圍環境缺氣：高山，礦坑
- 疾病：長期阻塞性肺病
- 運動
  ✓身體代謝增加

Outline

- Background (背景)
- Structure and function
- Ventilation
- Perfusion and ventilation/perfusion ratio
- Static/Dynamic respiratory mechanics
- Diffusion and gas transport
- Neural control of respiration
- Chemical control of respiration
- Acid-base balance
- Examples: exercise and high altitude adaptation

Background



- Systemic respiration: gas exchange between the external environment and the body
- Cellular respiration: the utilization of O_2 in metabolic pathways of cells for nutrient breakdown to get ATP

- Primary sites of gas exchange in lungs: alveoli (肺泡)
- Primary sites of cellular respiration: mitochondria (粒線體)

Background

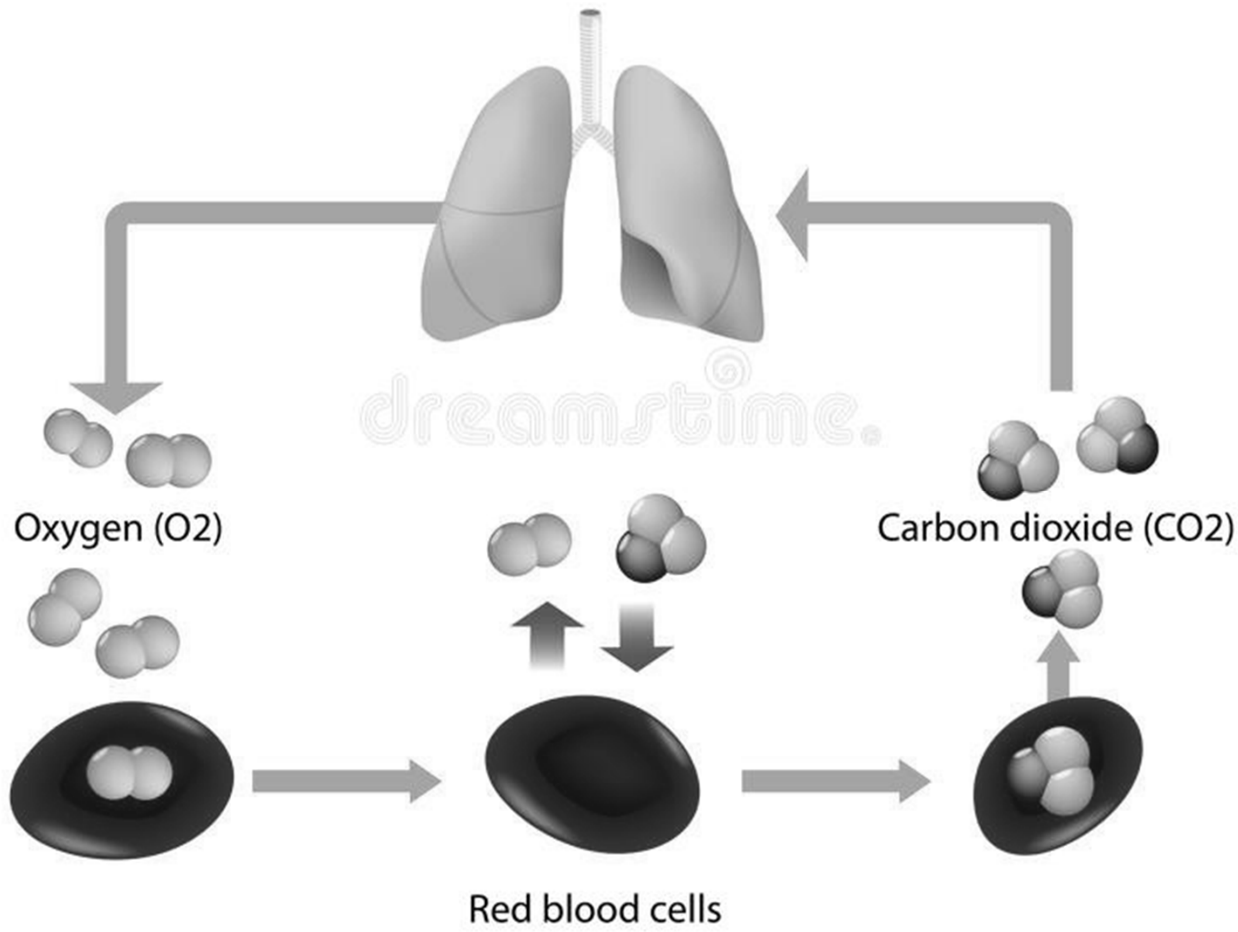
- Symbols and abbreviation
  - ✓ P: pressure
  - ✓ V: volume
  - ✓ $\dot{V}$: $\frac{dV}{dt}$; gas volume per unit time

    → rate of gas flow
- Conditions for measuring pressure and volume

STPD
- Standard temperature (0 ^{0}C)
- Standard pressure (1 atm; 760 mmHg)
- Dry air (no humidity)

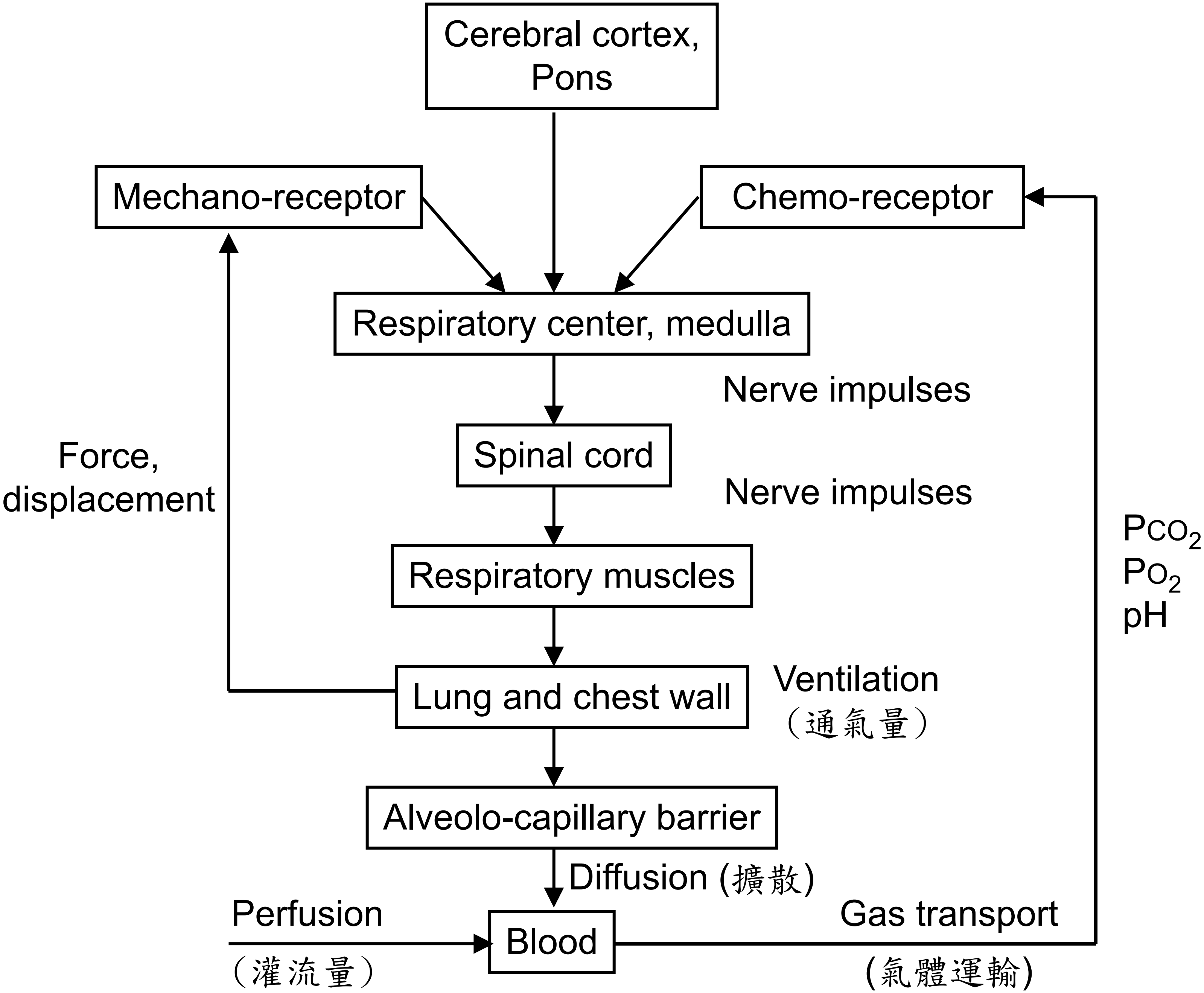
BTPS
- Body temperature (37 ^{0}C)
- Ambient pressure (variable)
- Air saturated with water vapor at body temp. (47 mmHg)

除了氣體交換(吸氧排二氧化碳)外，呼吸系統還有那些功能?



Functions of Respiratory Sys.

1. Supply O_2 to the body for metabolic processes in order to produce energy
2. Remove the byproducts of metabolism (CO_2 & H_2O)
3. Aid in acid/base regulation of blood (acidosis; alkalosis)
4. Temperature regulation
5. Enable vocalizations
6. Stress relief
7. Defend against inhaled foreign matter
8. Enhance venous return — respiratory pump
9. Modify materials passing through the circulatory system
   - ✓Activates angiotensin II (第二型血管張力素)
   - ✓Inactivates prostaglandins (前列腺素)



Cerebral cortex,
Pons
Mechano-receptor
Chemo-receptor
Respiratory center, medulla
Nerve impulses
Spinal cord
Nerve impulses
Force,
displacement
Respiratory muscles
P_{CO_2}
P_{O_2}
pH
Lung and chest wall
Ventilation
（通氣量）
Alveolo-capillary barrier
Diffusion (擴散)
Perfusion
（灌流量）
Blood
Gas transport
(氣體運輸)

Outline

- Background
- Structure and function (結構與功能)
- Ventilation
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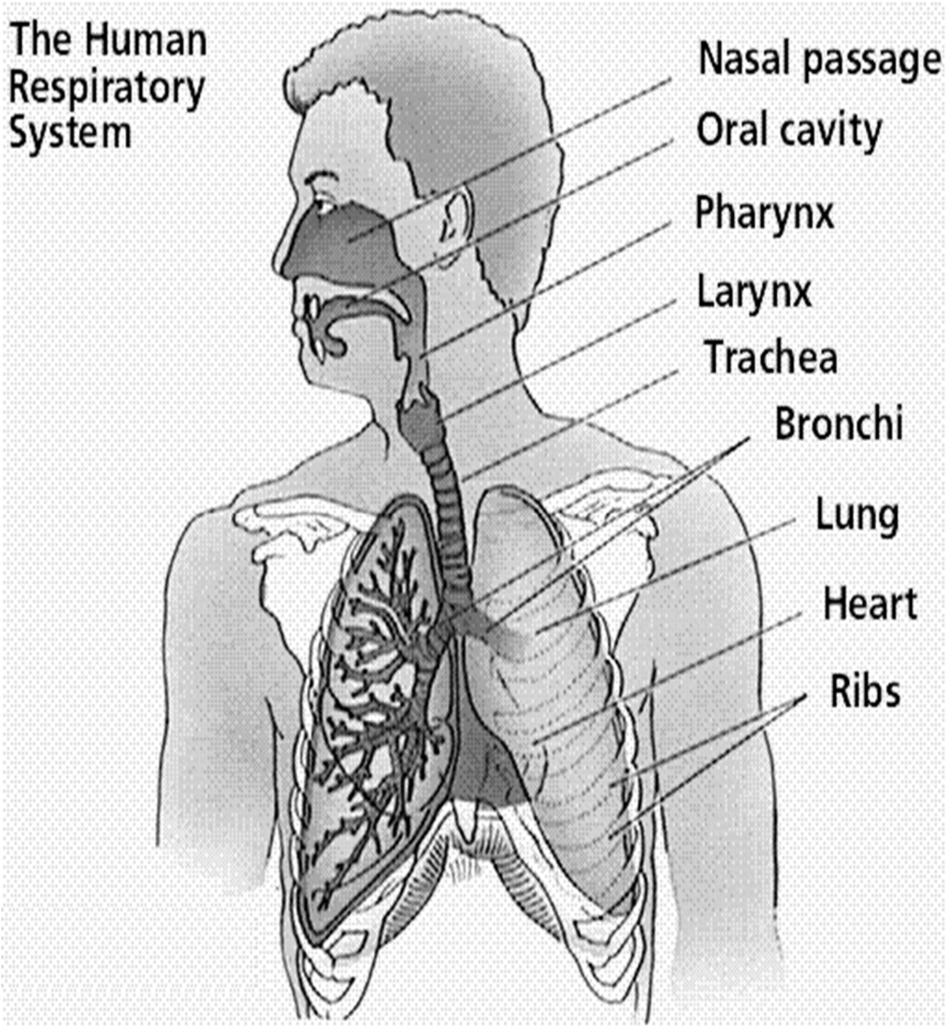
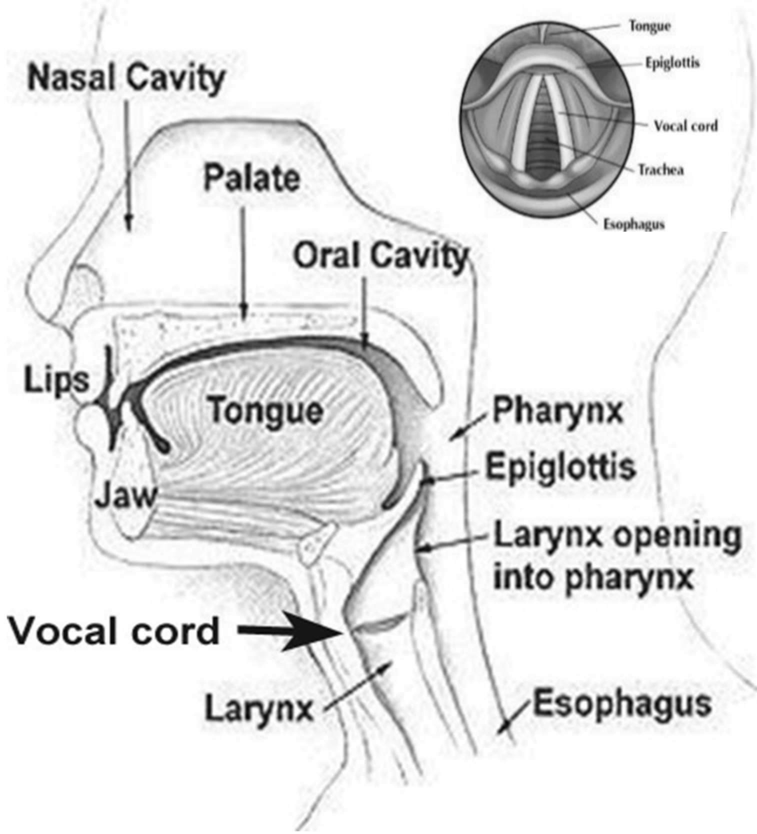
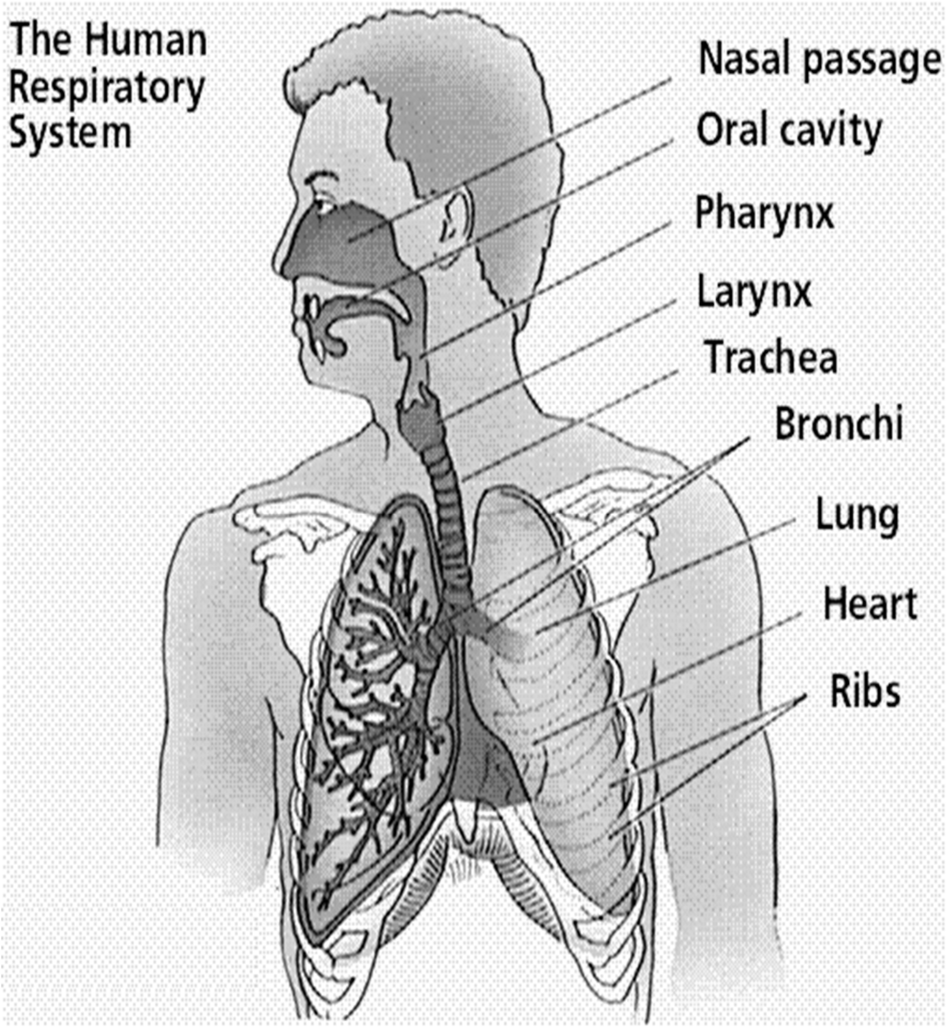
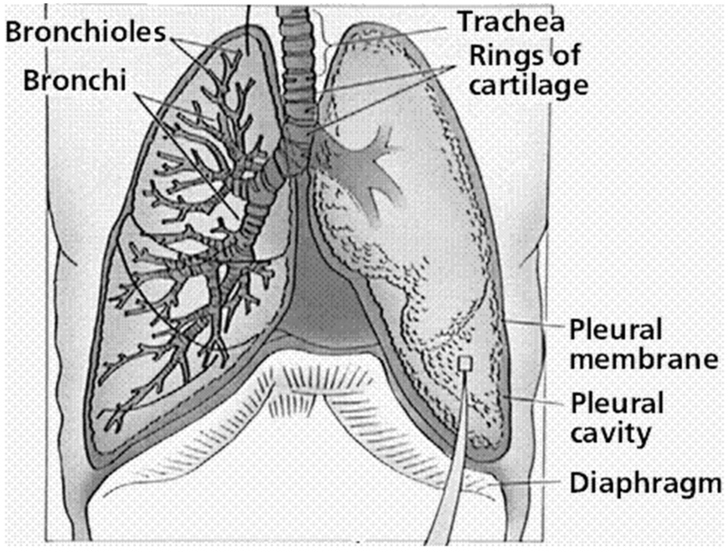
Structure of Respiratory Sys.

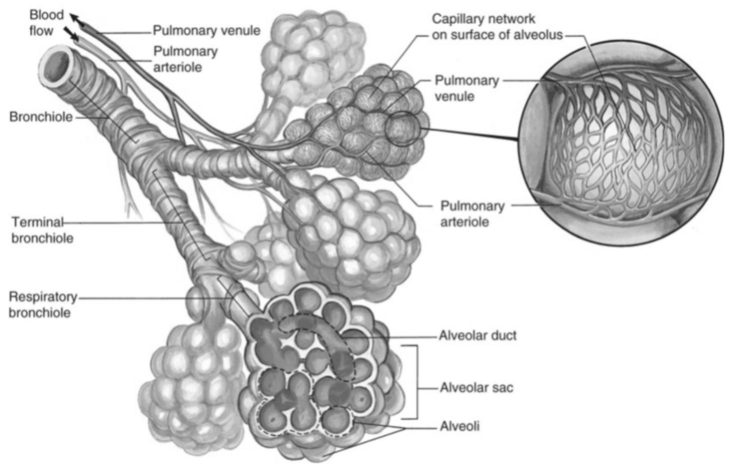




Structure of Respiratory Sys.

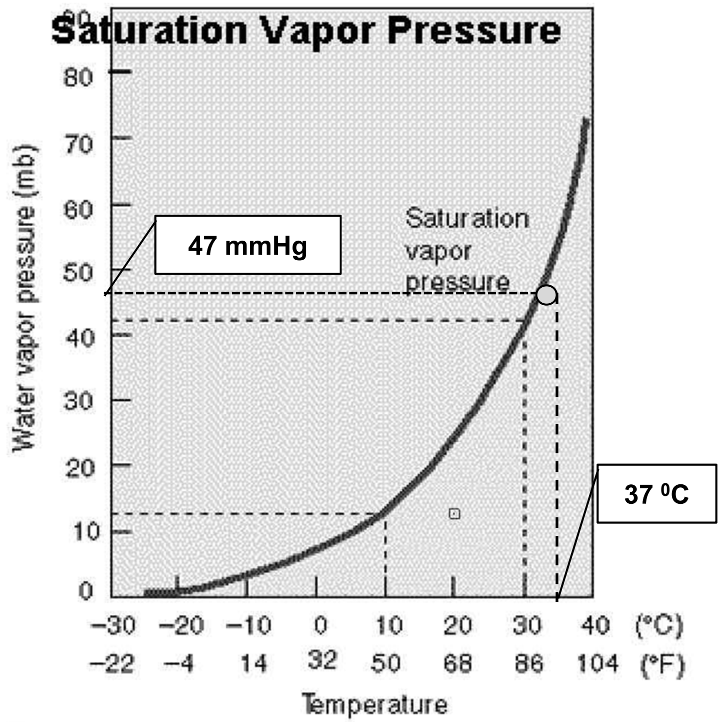


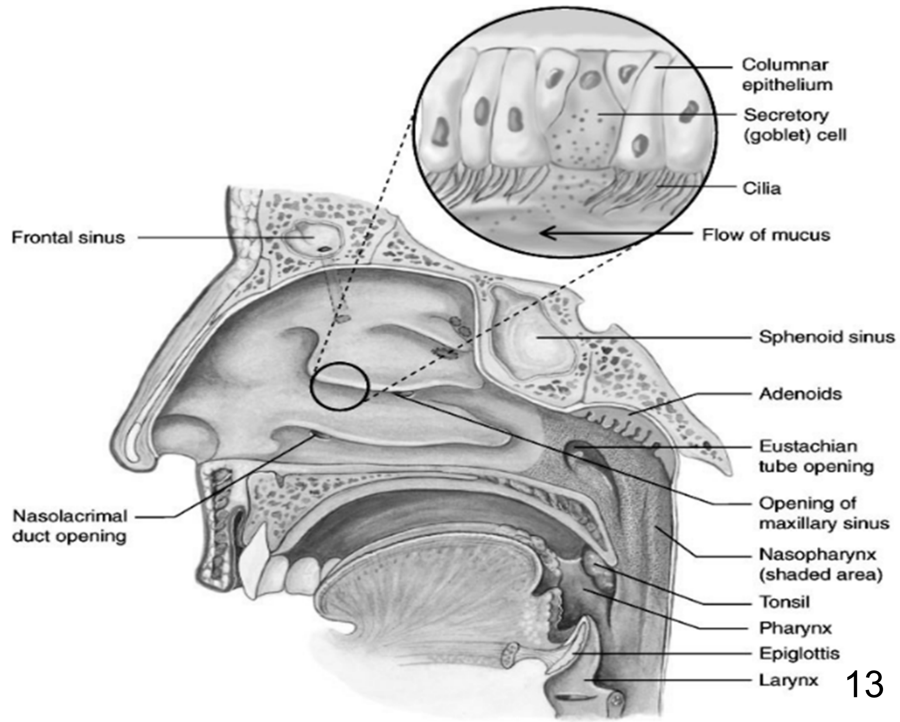




Function of Nasal Passage

- Clean the air – mucus and cilia filter airborne particles
- Warm the air – become as body temperature (37 ^{0}C)
- Humidify the air – saturated with H_2O to match vapor pressure (47 mmHg) within the body





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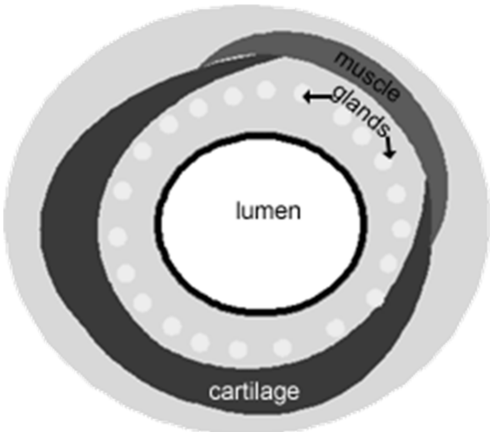
Comparison of Airway Structure

Trachea: supported by 15 to 20 C-shaped cartilages
- Oriented posteriorly and filled by smooth muscle

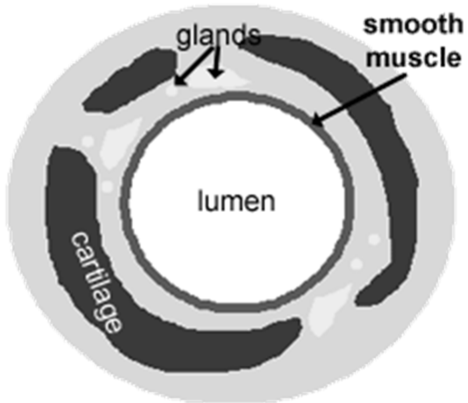
Bronchus: cartilage is in the form of irregular plates
- Smooth muscle forms complete rings

Bronchiole: no cartilage
- Smooth muscle layer is relatively thick

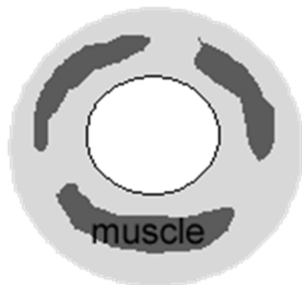
- All three structures are lined by a respiratory mucosa



Trachea

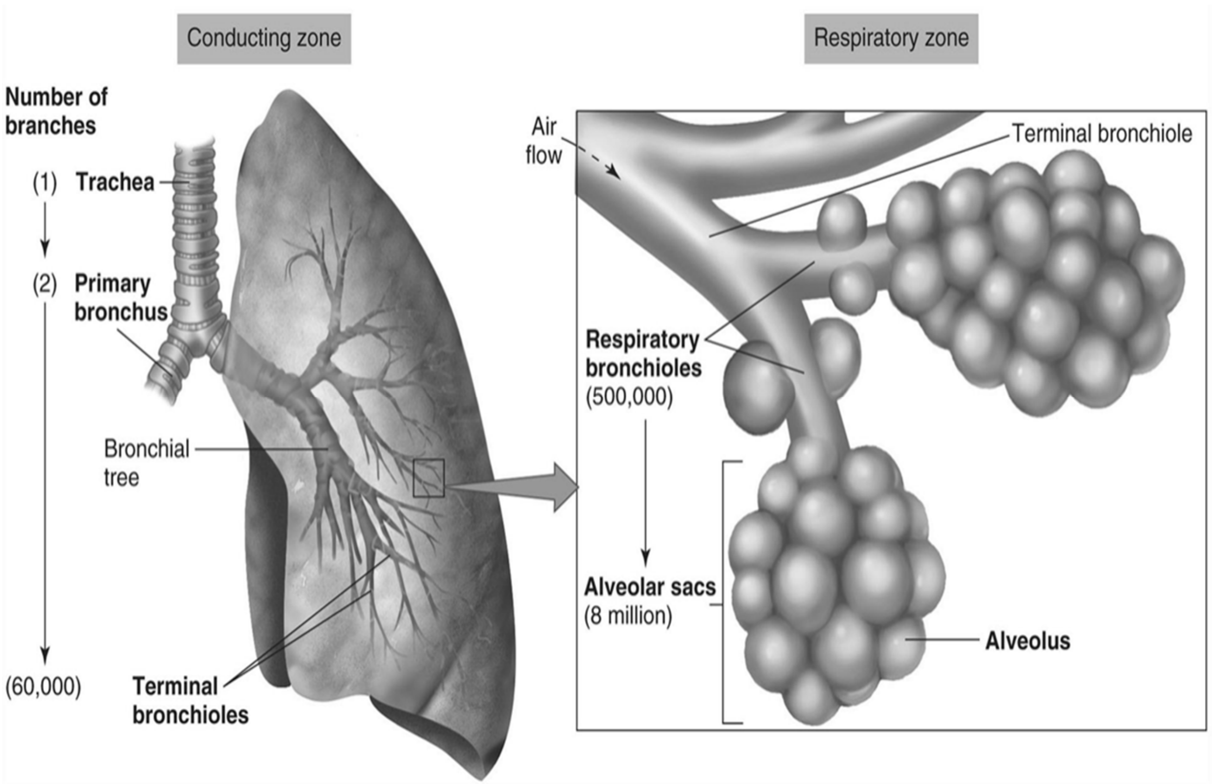


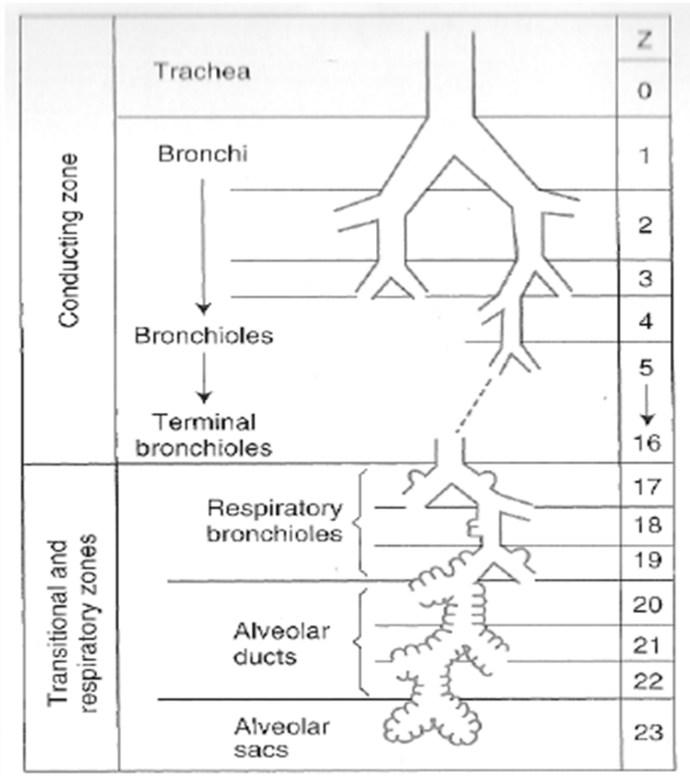
Bronchus



Bronchiole

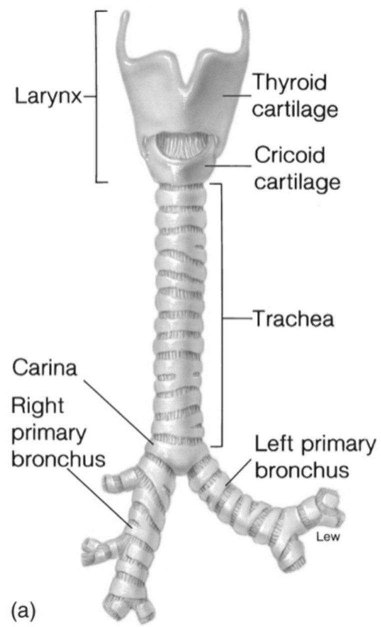
Airways of a Human Lung





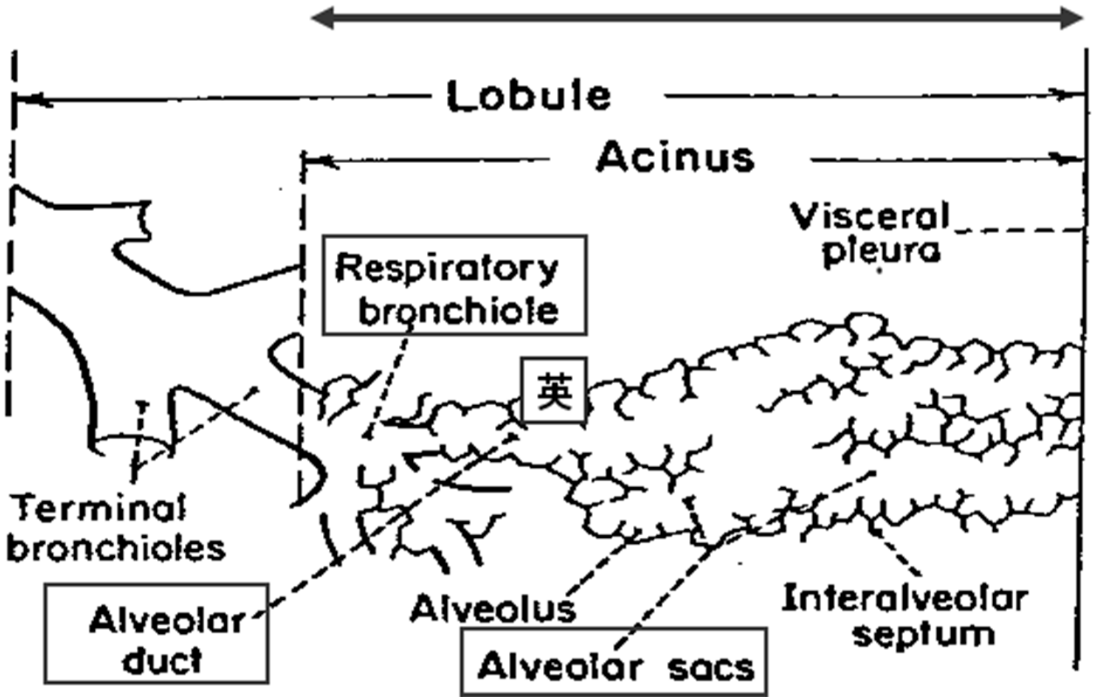
Main Airway Branches & Zones

- Conducting Zone (傳導區) (1-16 generations) (No gas exchange)
  - ✓ Trachea (1)
    - → R + L main bronchi (R't is less sharply angled)
    - → lobar bronchi
    - → segmental bronchi
    - → bronchioles
    - → terminal bronchioles ($6x10^4$)
- The first 16 branches are responsible for
  - ✓ Conducting air movement (by pressure)
  - ✓ Cleansing the air



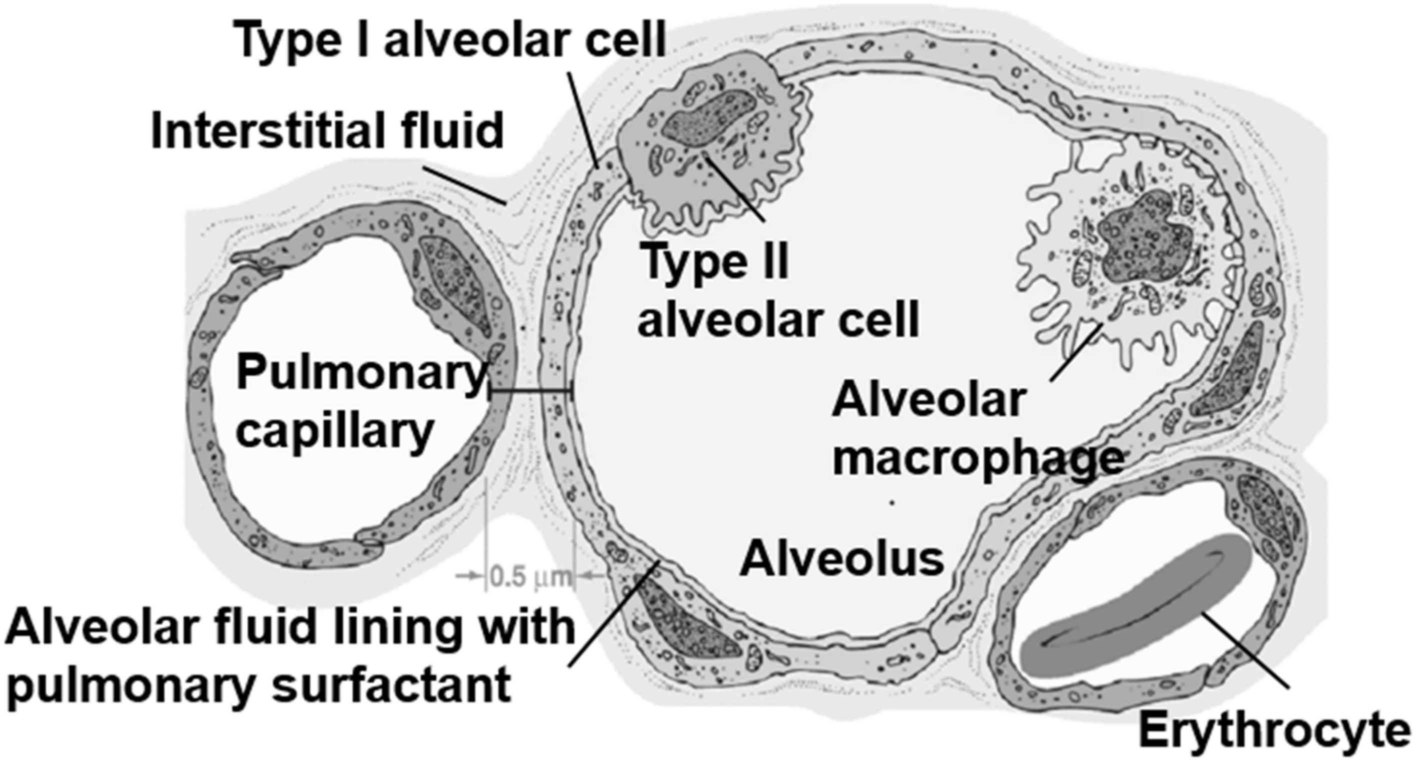
Main Airway Branches & Zones

- Respiratory Zone (呼吸區) (17-23 generations)
  - ✓ Gas movement by diffusion (擴散)
  - ✓ Respiratory bronchioles
    - → alveolar ducts
    - → alveolar sacs (8 x 10^6)

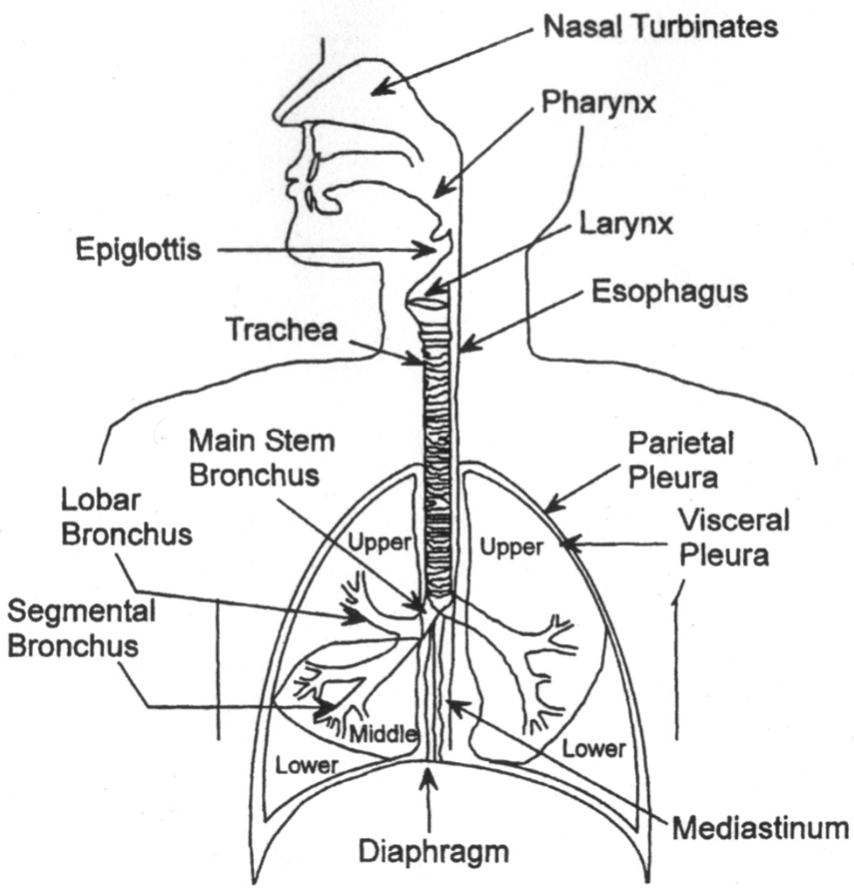


Alveoli

- Thin-walled, inflatable sacs
- Formed by a single layer of flattened Type I alveolar cells
- Type II alveolar cells secretes pulmonary surfactant
  - This substance facilitates lung expansion
- Encircled by pulmonary capillaries, offering tremendous surface area for gas exchange by diffusion

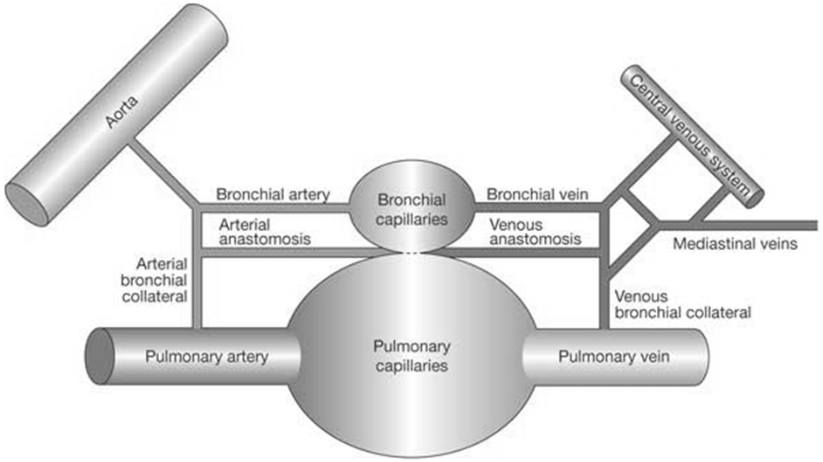


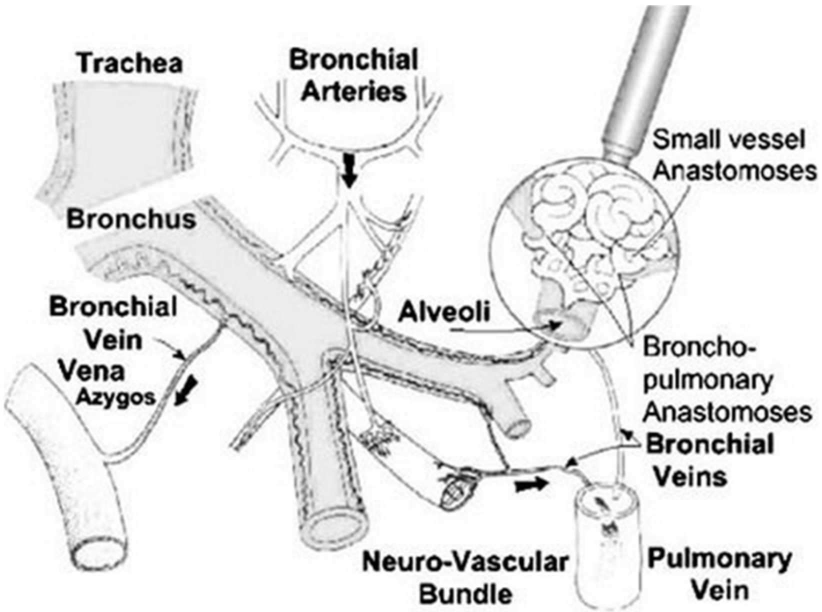
The Human Lung



- Includes airways and parenchyma (基質)
- Parenchyma: connective tissues and other non-airway components
- Parenchyma provides mainly the elastic recoil force

Blood Supply of Lungs



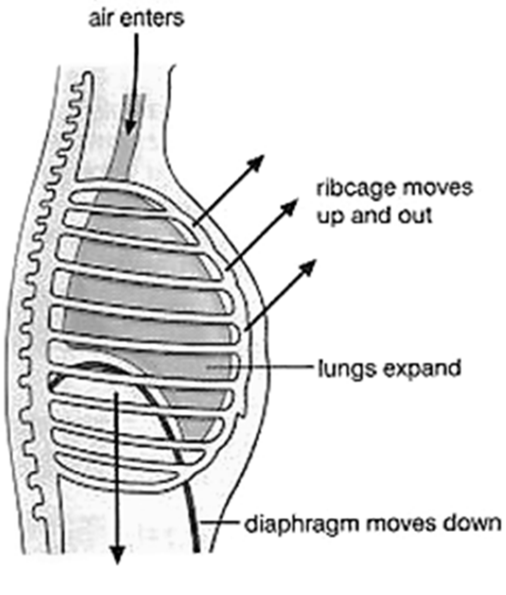


- Pulmonary circulation: gas exchange with the alveoli in the parenchyma → respiratory zone
- Bronchial circulation: main nutrient and O_2 supply for the airways → conducting zone

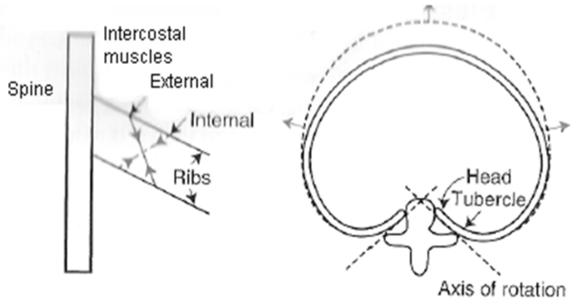
Respiratory Muscles

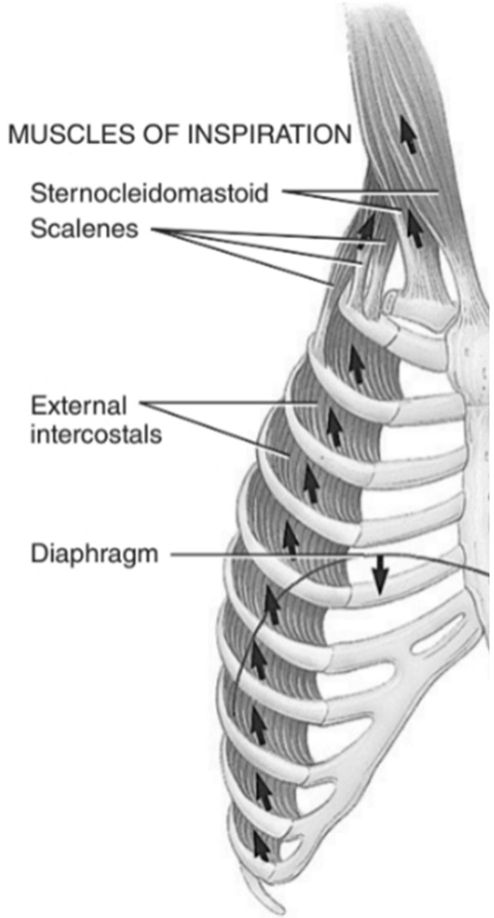
Inspiration

- Diaphragm: ↑longitudinal dimension of thorax
  - ✓ Major m. for inspiration, innervated by phrenic n.
    - ➢ hiccup
- External intercostal m.: ↑ ant-post. dimension of thorax
- Accessory m. of respiration: sternomastoids & scalenes



Inhalation





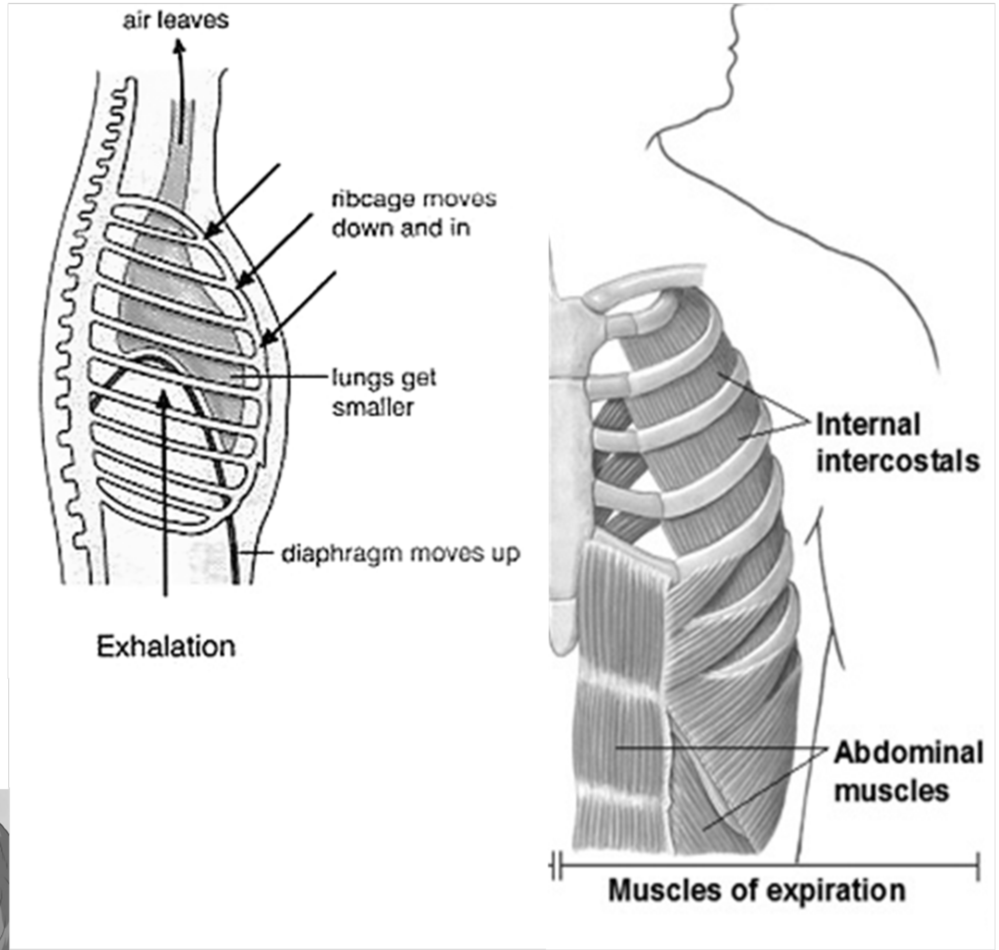
Respiratory Muscles

Expiration:

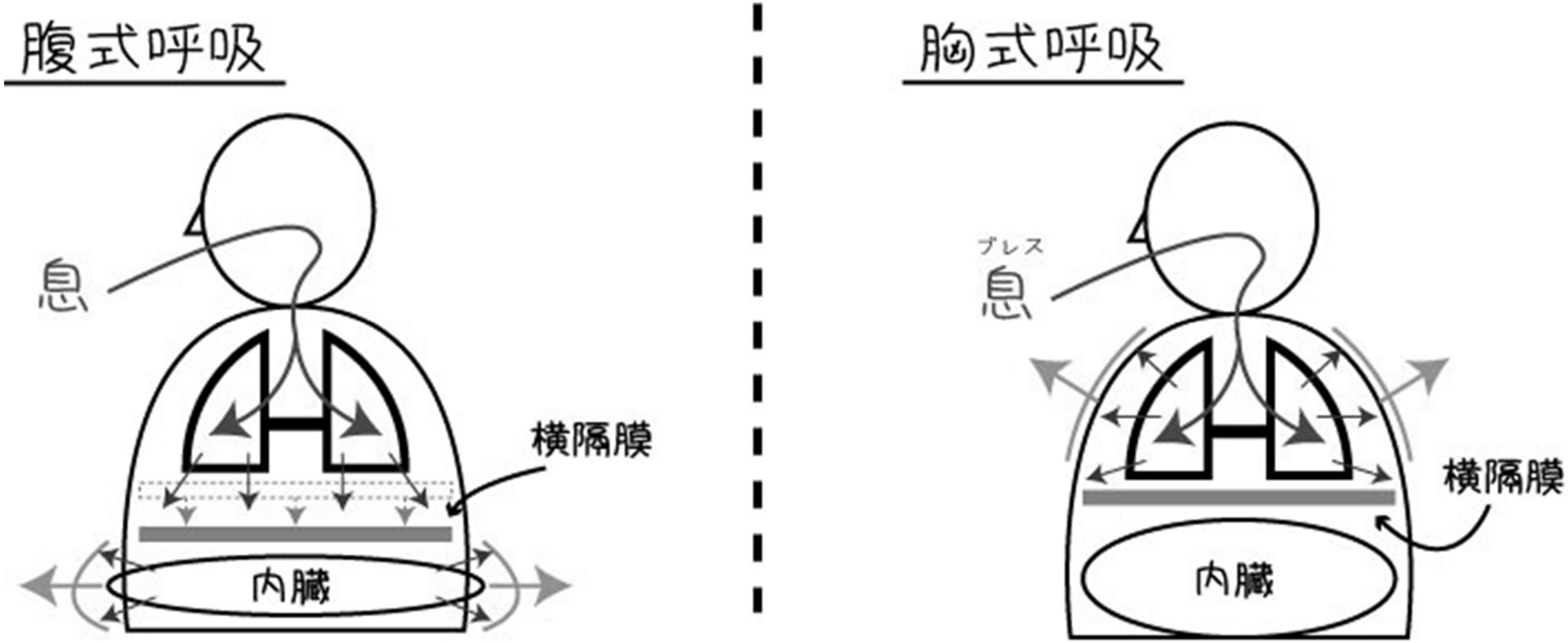
Under normal resting condition, expiration is a passive process, relying on the elastic recoil of the lung and chest wall

During forced expiration:

- Internal intercostal m.: ↓ ant-post. dimension of thorax
- Abdominal m.



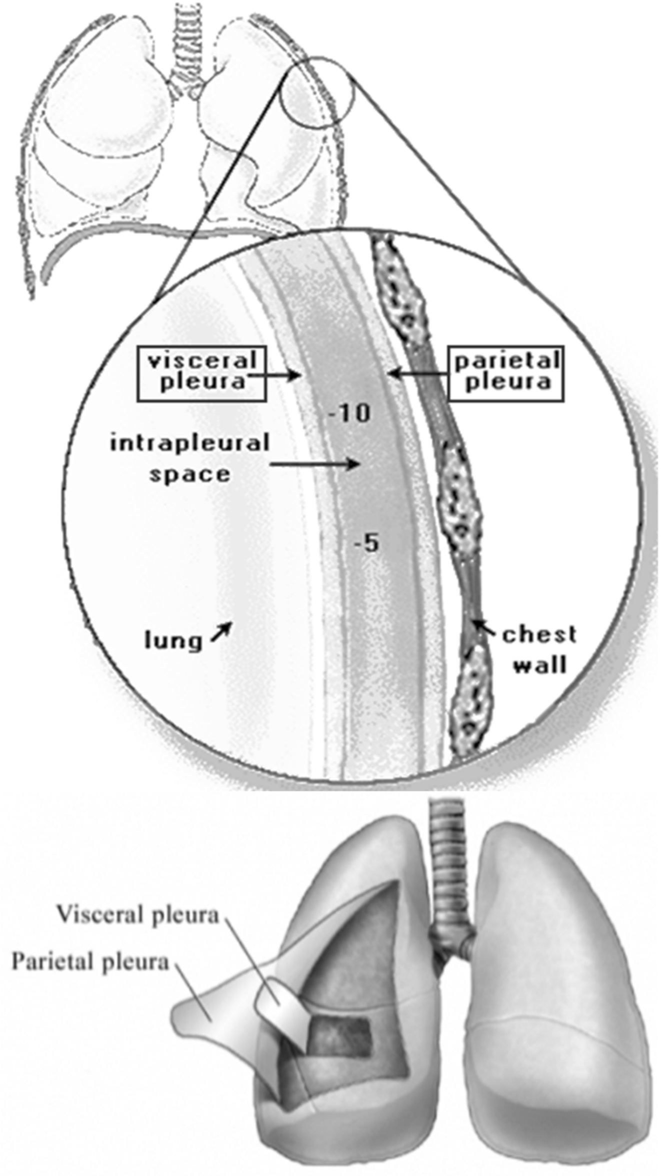
那種呼吸比較有效率?為什麼?



✓橫膈為最主要吸氣肌

✓當腹肌收縮，使吐氣吐的完全(較多廢氣排出)，下次吸氣即能吸較多的新鮮空氣

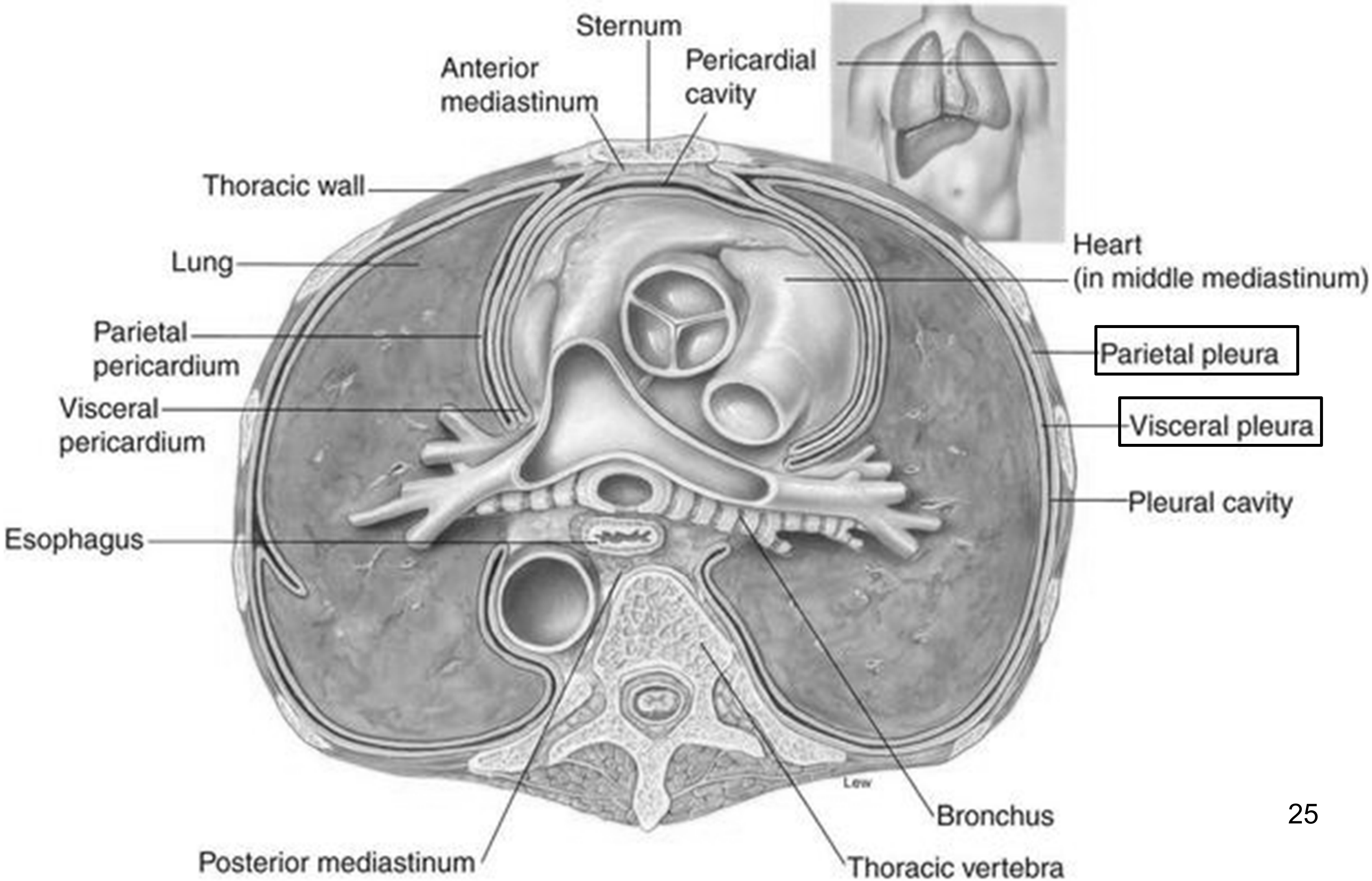
Pleural layers



- Visceral pleura (臟側肋膜): covers lungs
- Parietal pleura (壁側肋膜): covers inside of chest wall
- Intrapleural space (肋膜間腔): space between visceral pleura and parietal pleural

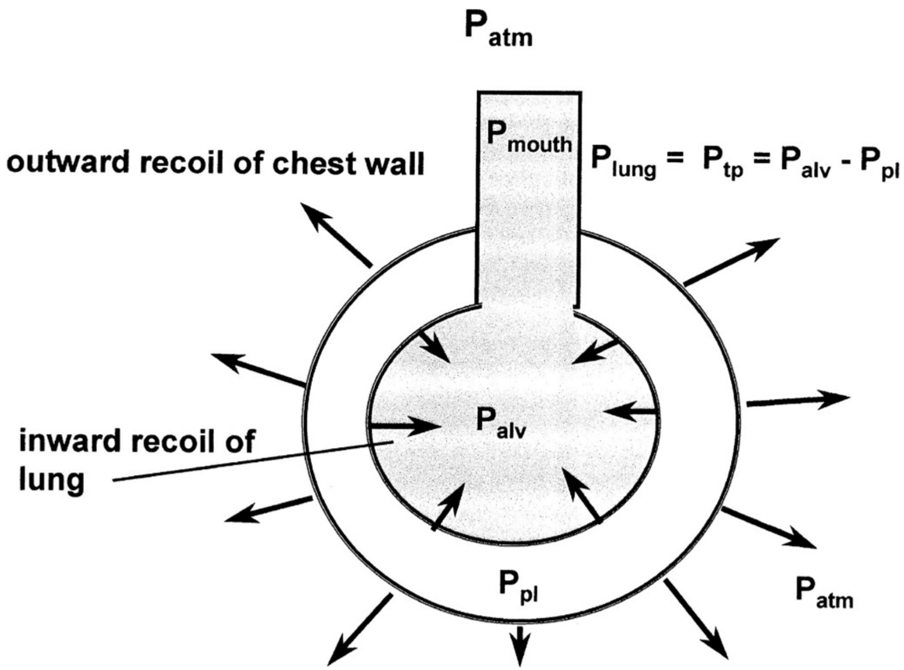
* Pleural coupling: lungs move with movement of chest wall

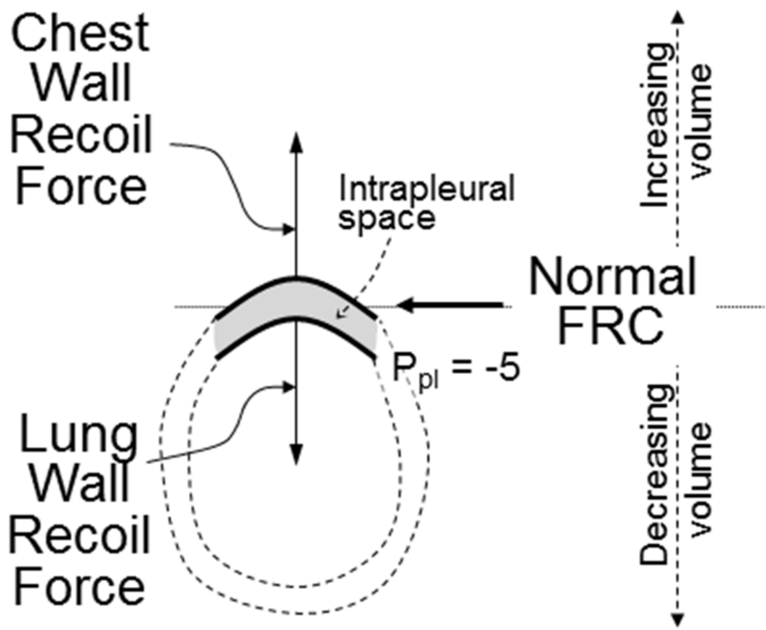
Cross Section of the Thoracic Cavity



Intrapleural Space

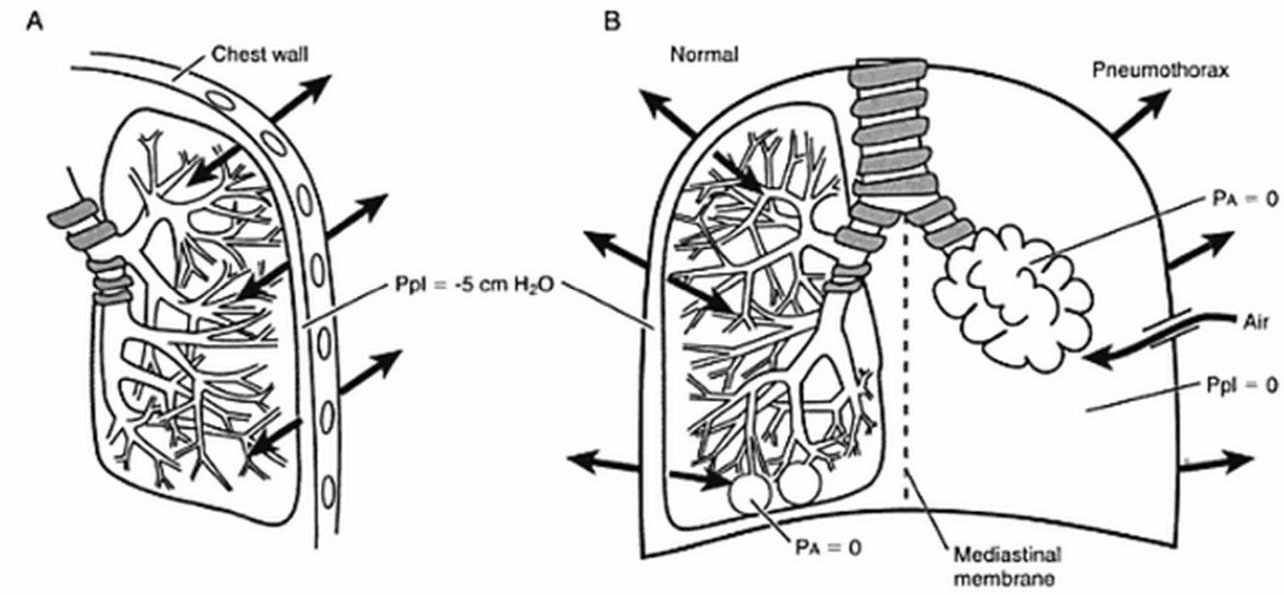
- Intrapleural pressure (P_{pl}): -4~5 cmH_2O at end-expiration (FRC, functional residual capacity)
  - ✓ Lungs have a tendency to collapse
  - ✓ Chest wall has a tendency to expand act in opposite direction
  - → Negative Intrapleural pressure

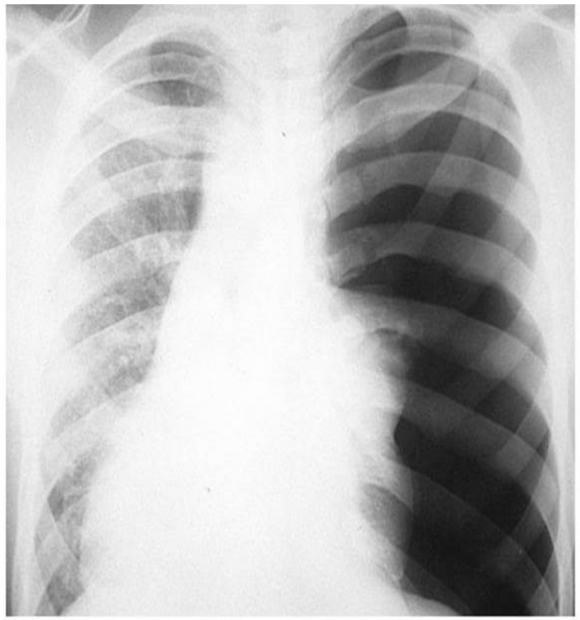




Pneumothorax

- Pneumothorax (氣胸): air is introduced to the fluid layer between the pleura causing them to come apart ($P_{pl} = 0$)
  - ✓ Loss of pleural coupling





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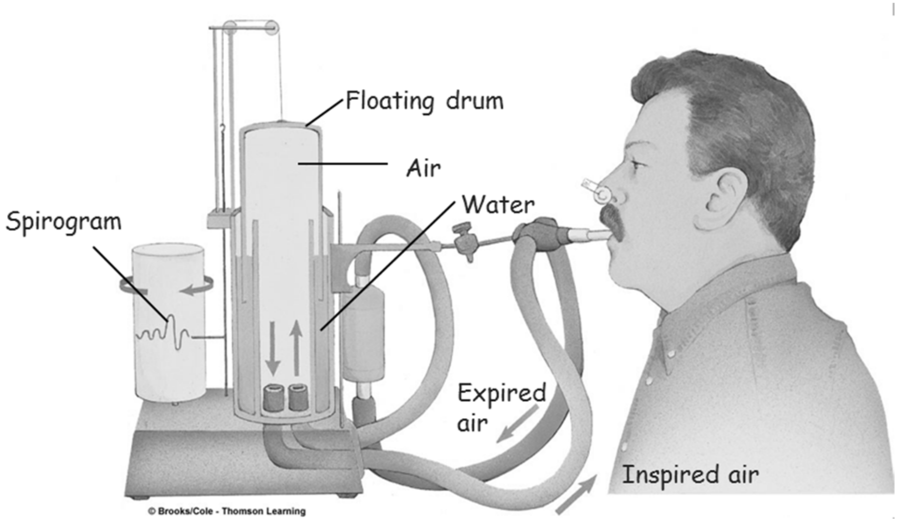
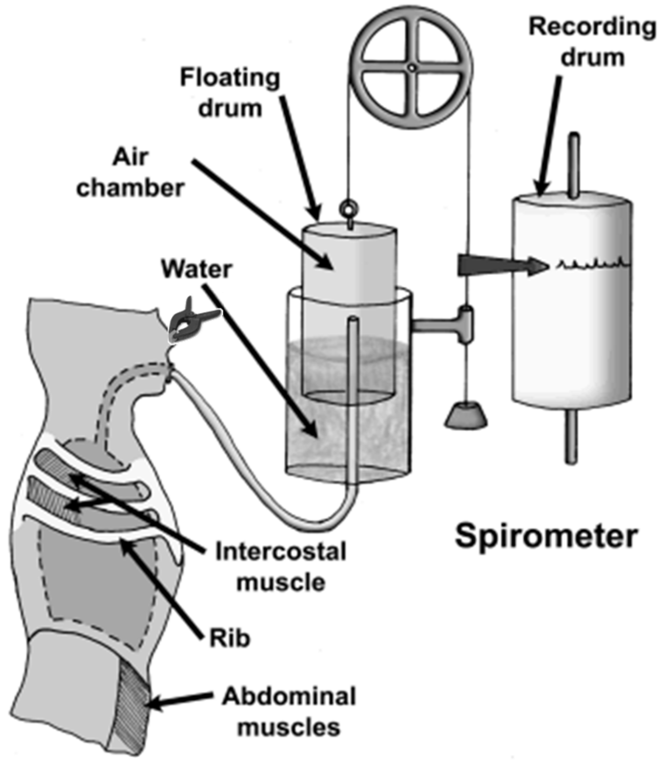
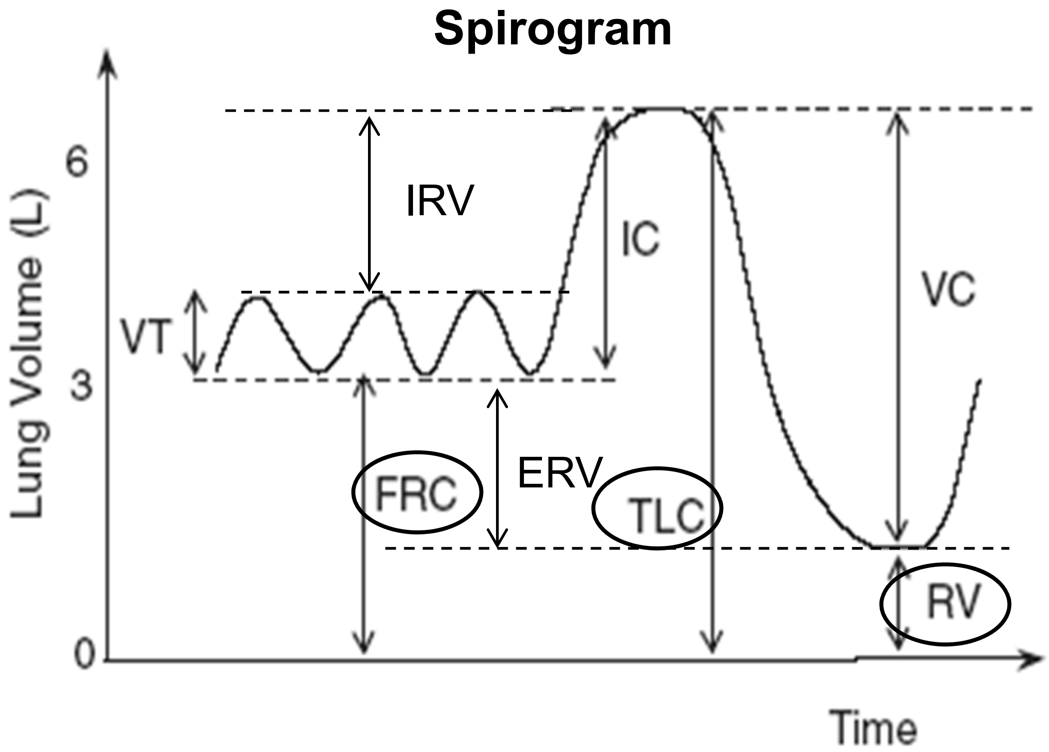
Instrument for Measuring Lung Vol.

- Spirometer (肺活量計): a device for measuring lung volumes (except *functional residual capacity, residual volume, total lung capacity*)
- Body plethysmograph (身體體積描記器): a method of obtaining the absolute volume of air within one's lungs
- Pneumotachograph (呼吸速度描記器): a device for measuring airflow velocity (Vol. is calculated by integration of flow)



Spirometer, Lung Volumes and Capacities



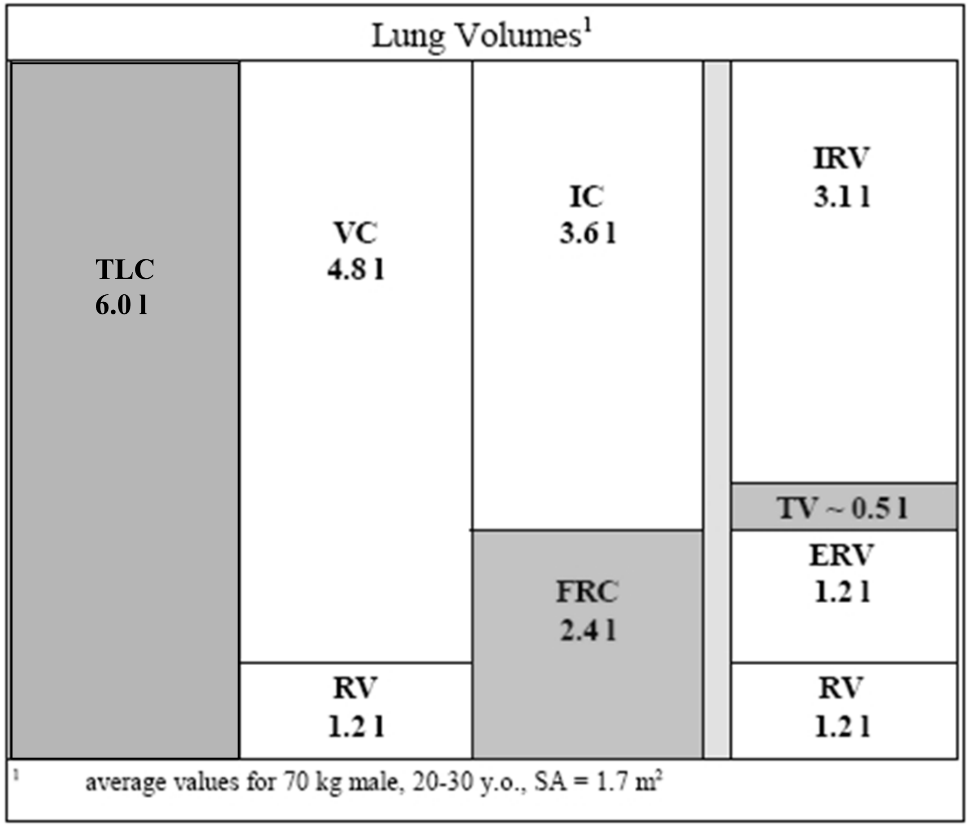


V_T: tidal volume (潮氣容積)
IRV: inspiratory reserve volume (吸氣儲備容積)
ERV: expiratory reserve volume (吐氣儲備容積)
IC: inspiratory capacity (吸氣量)

VC: vital capacity (肺活量)
RV: residual volume (殘餘容積)
TLC: total lung capacity (總肺量)
FRC: functional residual capacity (功能肺餘量)

Lung Volumes and Capacities

- Capacity (量) = the summation of volume (容積)
- Primary lung volume: RV, ERV, V_T, IRV
- Secondary derived capacities: TLC, VC, IC, FRC

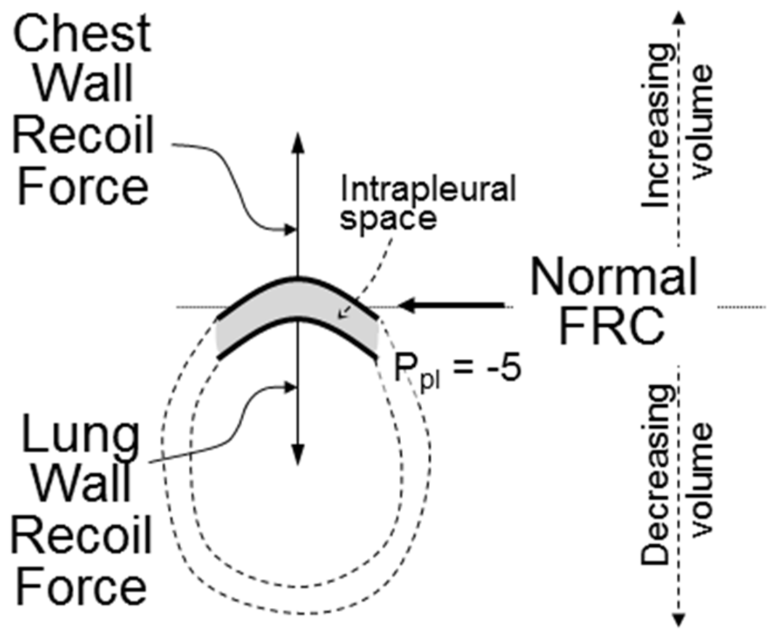


- IC = IRV + V_T
- FRC = ERV + RV
- VC = IRV + V_T + ERV
- TLC = IC + FRC
  =IRV + V_T + ERV + RV

什麼時候正常吐氣結束?

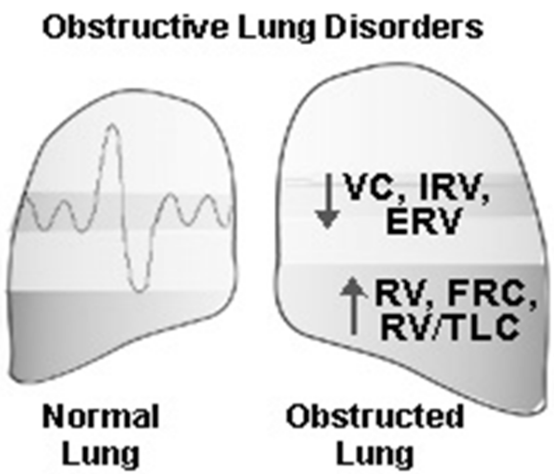
A) 肺中的氣體完全吐光

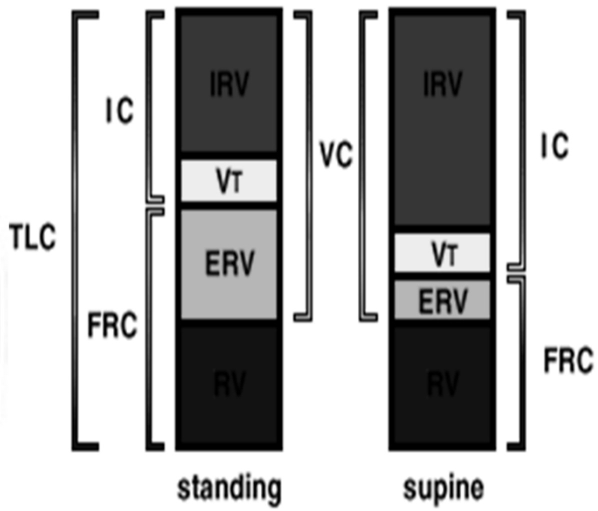
B) 肺向內縮的彈力等於胸腔壁向外擴張的力

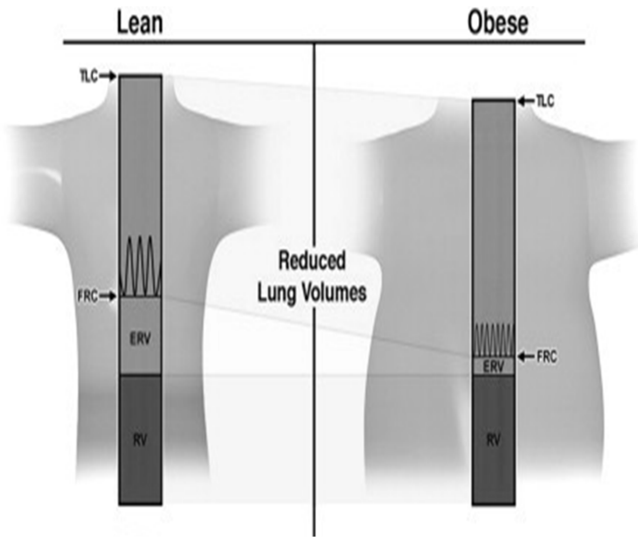


Functional Residual Capacity

- The vol. of gas left in the lungs at the end of normal tidal expiration
- Determined by a balance between the inward elastic forces of the lung and the outward forces of the chest wall
- Factors ↓ FRC: supine, obesity, pregnancy, anesthesia
- Factors ↑ FRC: height, obstructive lung disease





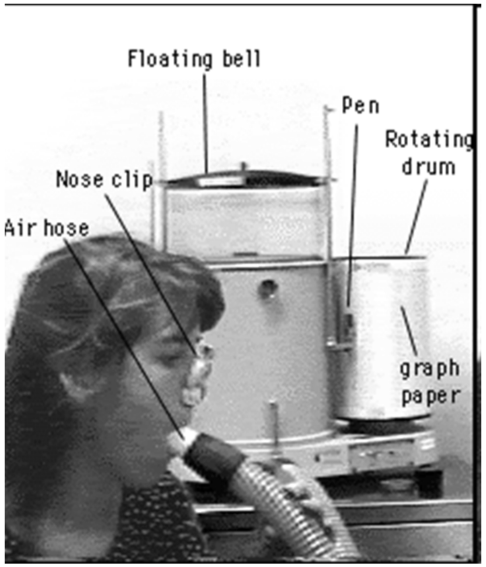


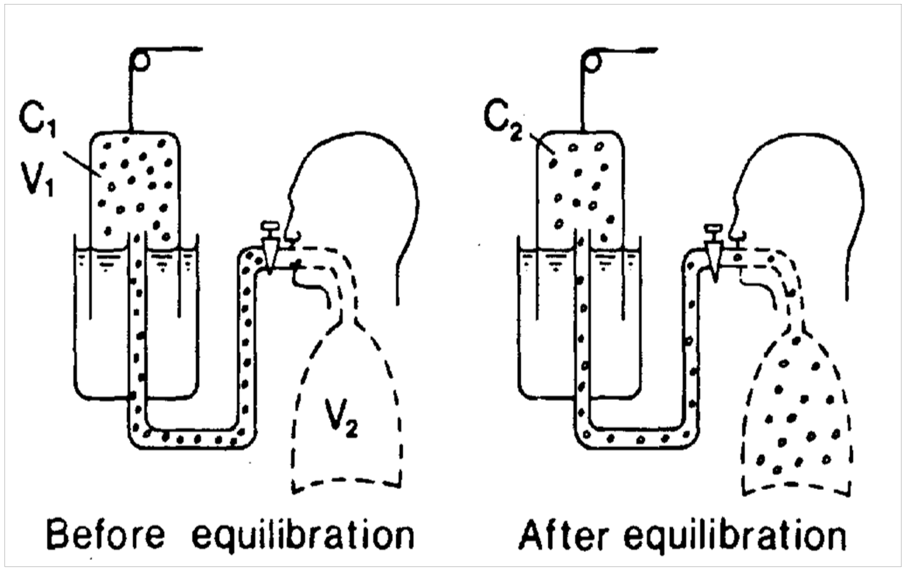
Measurement of FRC

Method 1: Closed circuit helium dilution

- Gas: insoluble inert gases (e.g. helium or neon)
- Principle: law of conservation of mass
  → check concentration change

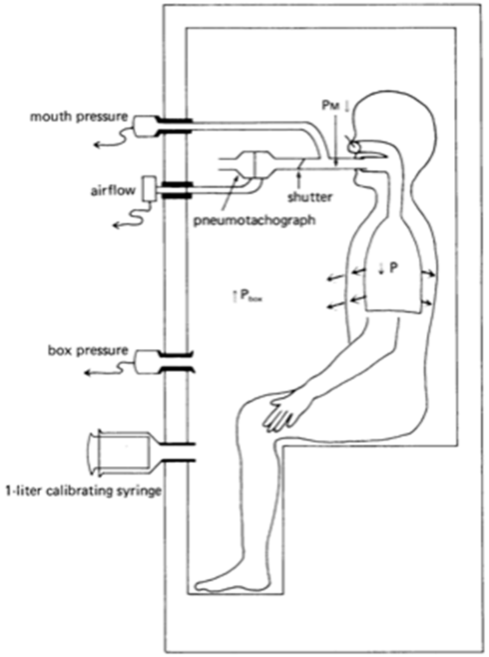
$$C_1V_1 = C_2\,(FRC + V_1)$$





Measurement of FRC

Method 2: Body plethysmograph method



Principle: PV = nRT (Boyle's law)

→ check pressure change

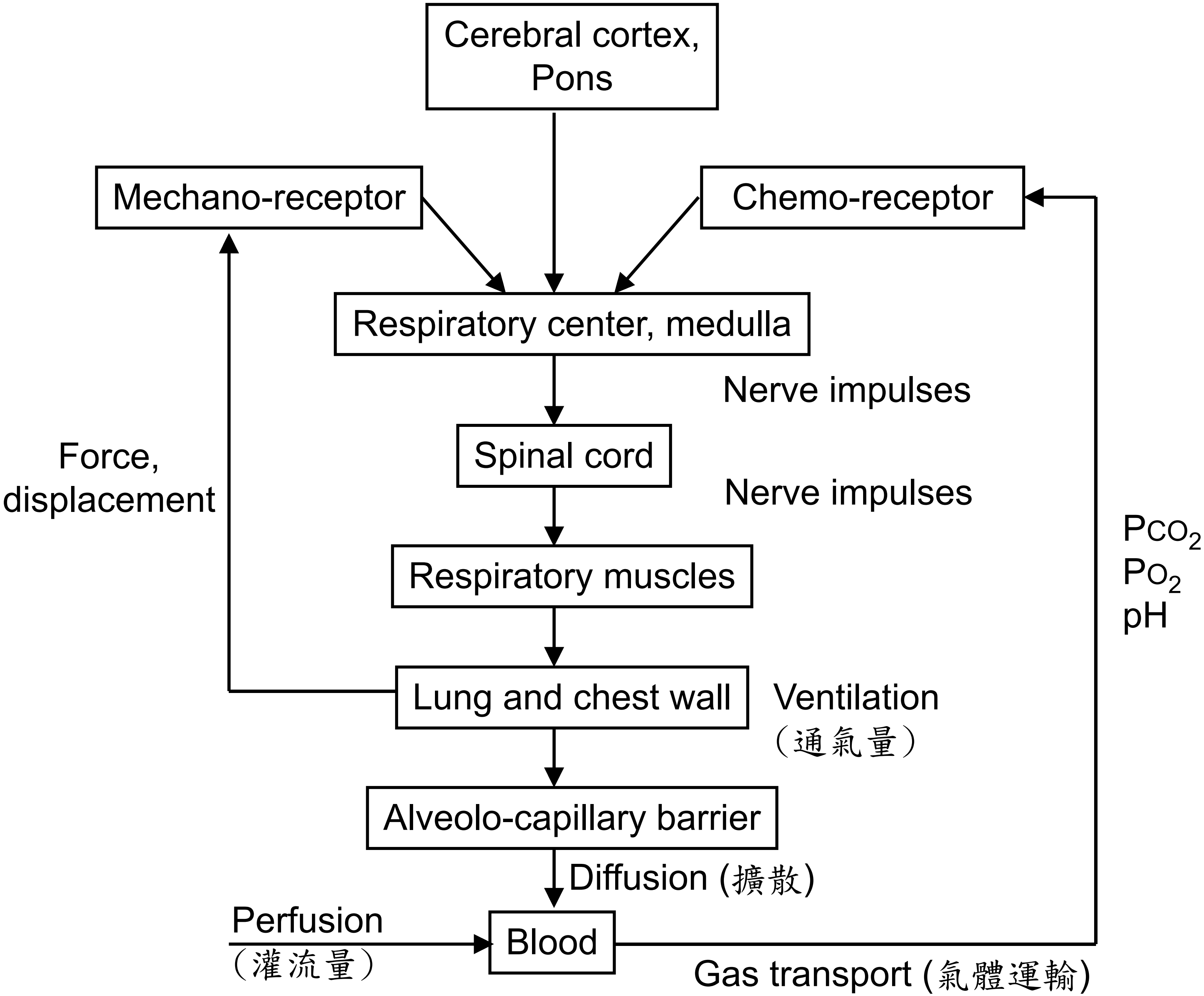
- $P_{aw} \cdot FRC = P'_{aw} \cdot (\Delta V_{lung} + FRC)$

→ $FRC = \dfrac{P'_{aw} \cdot \Delta V_{lung}}{P_{aw} - P'_{aw}}$

Because $\Delta V_{lung} = \Delta V_{box}$

ΔV_{box} can be calculated by measuring ΔP_{box}

- $P_{box} \cdot V_{box} = (P_{box} + \Delta P_{box}) \cdot (V_{box} - \Delta V_{box})$


Cerebral cortex, Pons
Mechano-receptor
Chemo-receptor
Respiratory center, medulla
Nerve impulses
Spinal cord
Force, displacement
Nerve impulses
Respiratory muscles
P_{CO_2}
P_{O_2}
pH
Lung and chest wall
Ventilation (通氣量)
Alveolo-capillary barrier
Diffusion (擴散)
Perfusion (灌流量)
Blood
Gas transport (氣體運輸)

Ventilation（通氣量）

- The movement of air in and out of the resp. system
- Minute ventilation ($\dot{V}$): volume of gas leaving (V_E) or entering (V_I) lungs per min
- $\dot{V}$ (ml/min) = V_T (ml) x resp. rate (1/min)

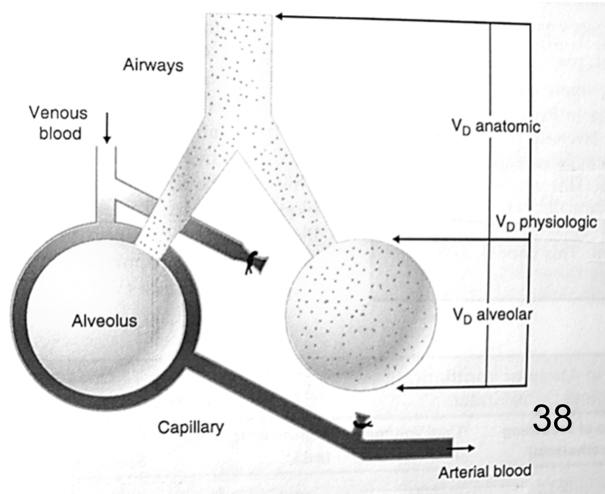
  E.g., $\dot{V}_E = V_T \times f$

  $= 500 \times 15 = 7500$ ml/min
- Changes in respiratory rate cause proportionate changes in minute ventilation ($\dot{V}_E$)

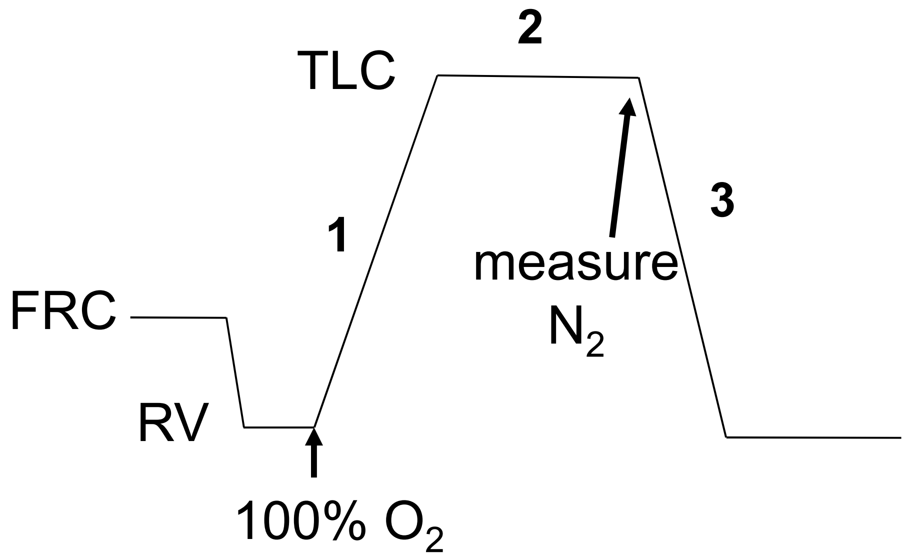
- NOT ALL inspired air is gas exchanged
- Dead space (死腔; V_D): area where there is no gas exchange, e.g. 1-16 generation of airway

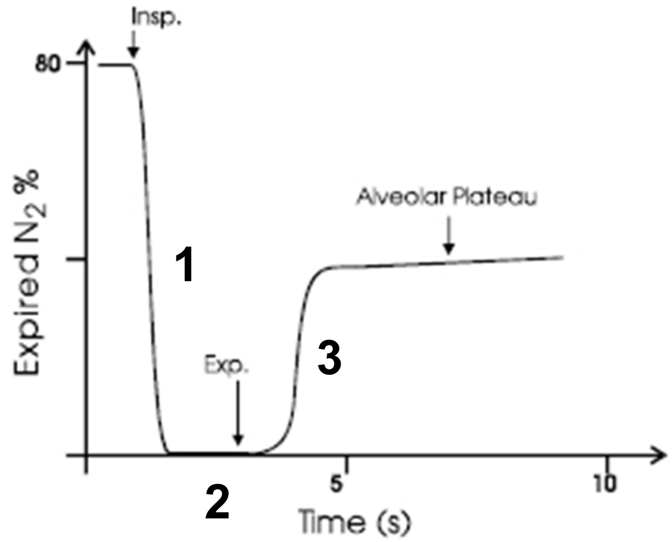
Dead Space（死腔）

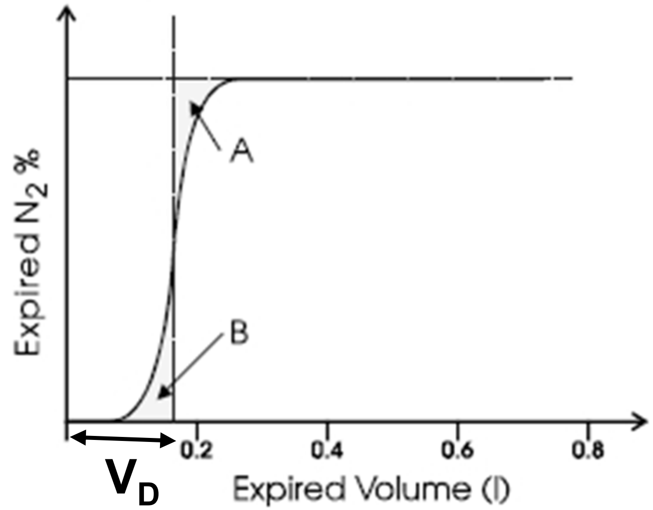
- Anatomic dead space (V_D^{Anat}): the volume of the conducting airways in which no gas exchange takes place
- Alveolar dead space (V_D^{Alv}) : inspired gas which enters alveoli (respiratory zone), however is ineffective in arterializing mixed venous blood
  - ✓ Alveoli with no perfusion or reduced perfusion
- Physiologic dead space (V_D^{Phys}): the volume of gas that does not eliminate CO_2
  - ✓ $V_D^{Phys} = V_D^{Anat} + V_D^{Alv}$
- Methods to measure dead space
  - ✓ Anatomic V_D: Fowler's method
  - ✓ Physiological V_D: Bohr's method



Fowler's Method: Single-Breath Nitrogen Washout







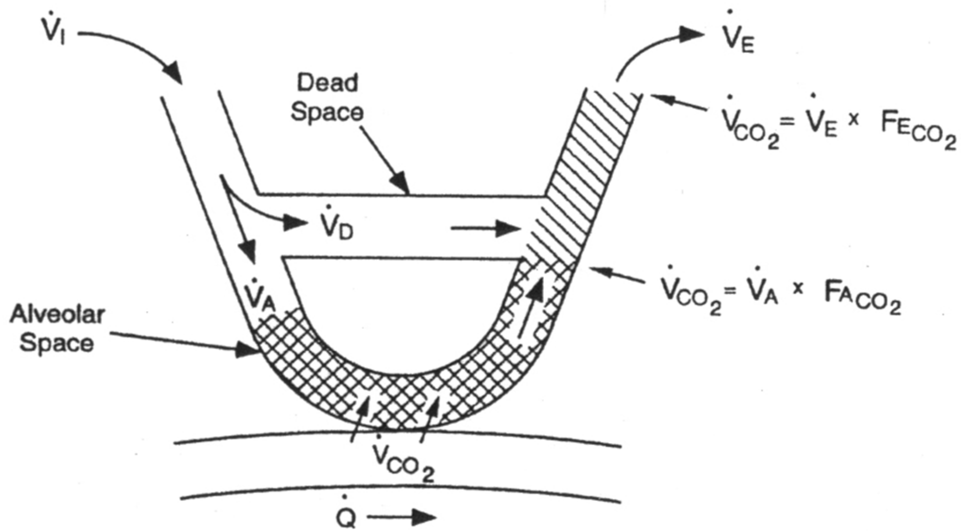
- Anatomic dead space is the exhaled volume to the point of transition between dead space and alveolar gas
- V_D^{Anat} ~ 2.2 ml/kg of body weight

Bohr's Method: Conservation of Mass

- Principle: V_D does not contribute to expired CO_2
- $\dot{V}_T \times F_{ECO2} = \dot{V}_A \times F_{ACO2}$
- $\dot{V}_A = \dot{V}_T - \dot{V}_D$

  $\rightarrow \dot{V}_T \times F_{ECO2} = (\dot{V}_T - \dot{V}_D) \times F_{ACO2}$

  $\rightarrow \frac{\dot{V}_D}{\dot{V}_T} = \frac{F_{ACO2} - F_{ECO2}}{F_{ACO2}}$ (Bohr Equation)



Dalton's Law

- Atmosphere contains a mixture of gases
  - ✓ O_2 (20.93%); N_2 (78.09%); CO_2 (0.03%); inert gas
- Dalton's law:

$$P_x = F_x \times P_{total}$$

  - ✓ In STPD, $P_{O2} = F_{O2} \times P_{atm} = 0.2093 \times 760 = 159$ mmHg
  - ✓ In BTPS, $P_{O2} = F_{O2} \times (P_{atm} – P_{H2O})$

    $= 0.2093 \times (760 – 47) = 150$ mmHg
    - ➢ The sum of gases must equal barometric pressure
    - ➢ P_{H_2O} = 47 mmHg at body temp.

Bohr's Method (2)

- $\frac{\dot{V}_D}{\dot{V}_T} = \frac{F_{ACO2} - F_{ECO2}}{F_{ACO2}}$ (Bohr Equation)

Dalton's law:

- $P_x = F_x \times P_{atm}$ [dry] (STPD)
- $P_x = F_x \times (P_{atm} - P_{H2O})$ [wet] (BTPS)

$$\rightarrow \dot{V}_D = \frac{P_{ACO2} - P_{ECO2}}{P_{ACO2}} \times \dot{V}_T$$

Example:

$P_{ACO2} = 40$ mmHg; $P_{ECO2} = 28$ mmHg

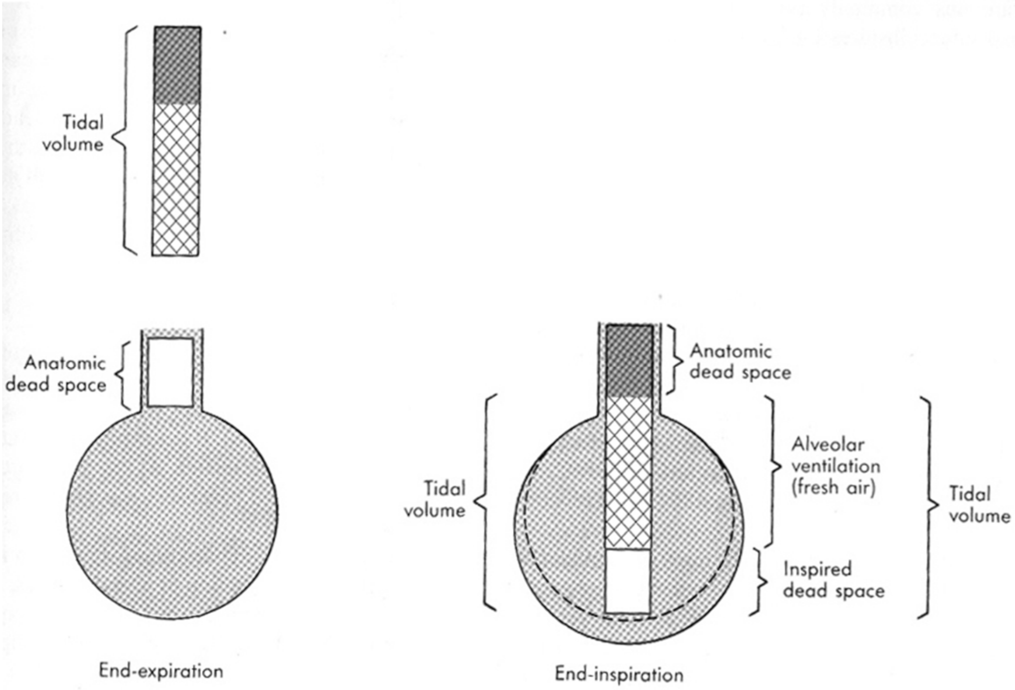
$$V_D = \frac{40 - 28}{40} \times 500 = 150 \text{ ml}$$

Alveolar Ventilation

- Alveolar vol.: the volume of fresh gas entering the alveoli and effective in arterializing mixed venous blood

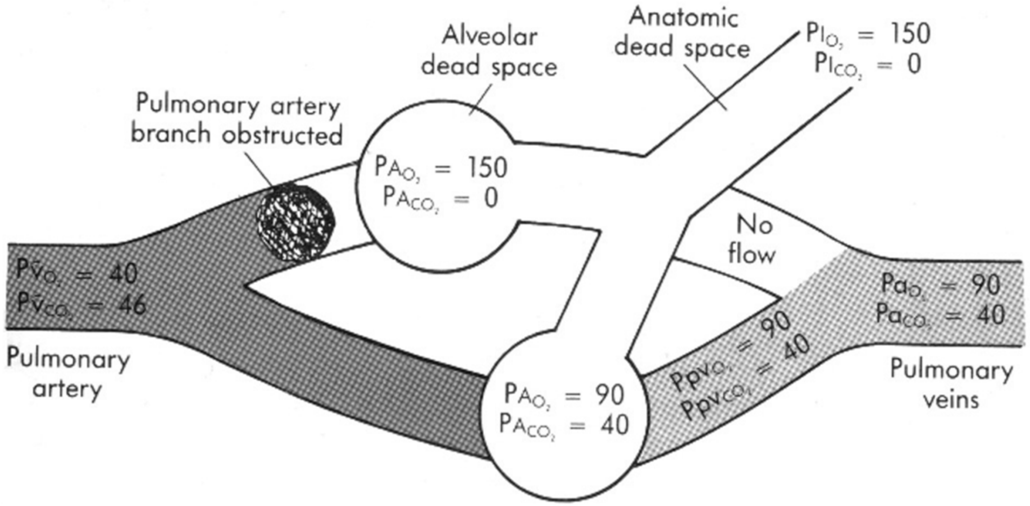
$$V_A = V_T - V_D^{Phys}$$

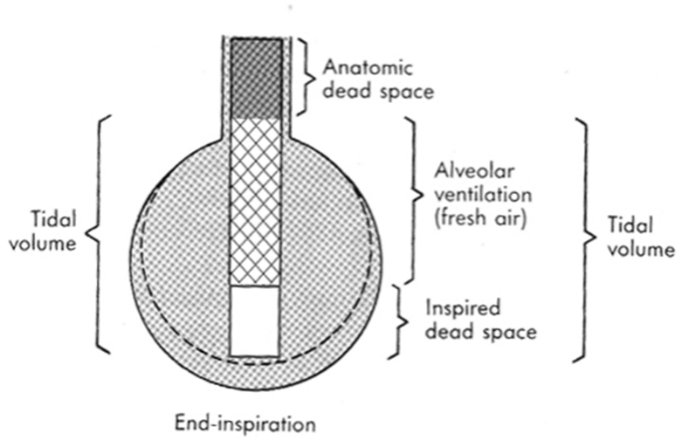
V_A: alveolar vol.



Alveolar Ventilation

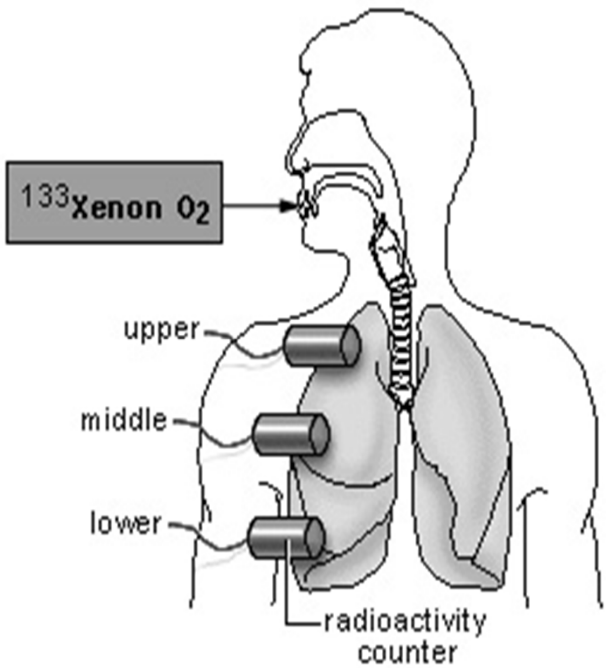
- $V_D^{Phys} = V_D^{Alv} + V_D^{Anat}$
- In normal supine man, $V_D^{Alv} \sim 0 \rightarrow V_D^{Phys} \approx V_D^{Anat}$
- $\dot{V}_A = \dot{V}_T - \dot{V}_D^{anat} = (V_T - V_D) \times f$
- Changes in respiratory rate cause proportionate changes in alveolar ventilation ($\dot{V}_A$)

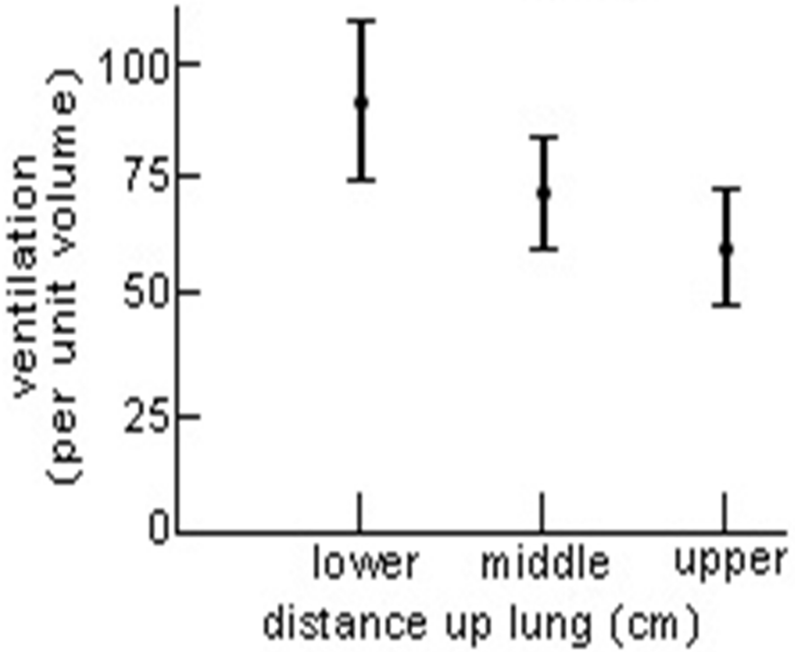




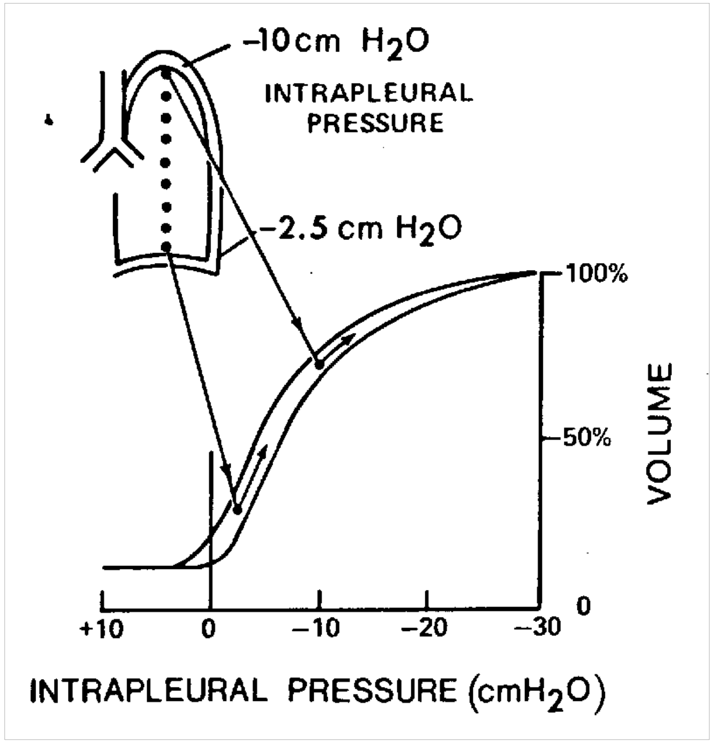
Uneven Ventilation in Upright Position

- Regional differences in airway resistance & compliance → different alveolar filling time
- In the upright position, ventilation is maximal at the lung bases, decreasing linearly to the apices



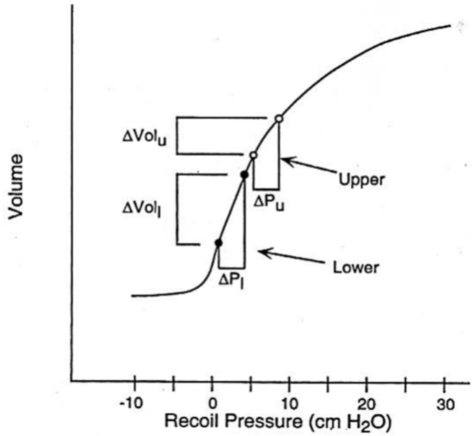


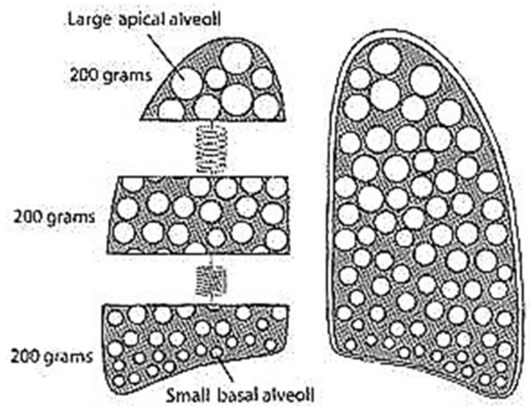
Cause of the Regional Differences of Ventilation



Because the weight of the lung,
the intrapleral pr. is less negative at the base than at the apex

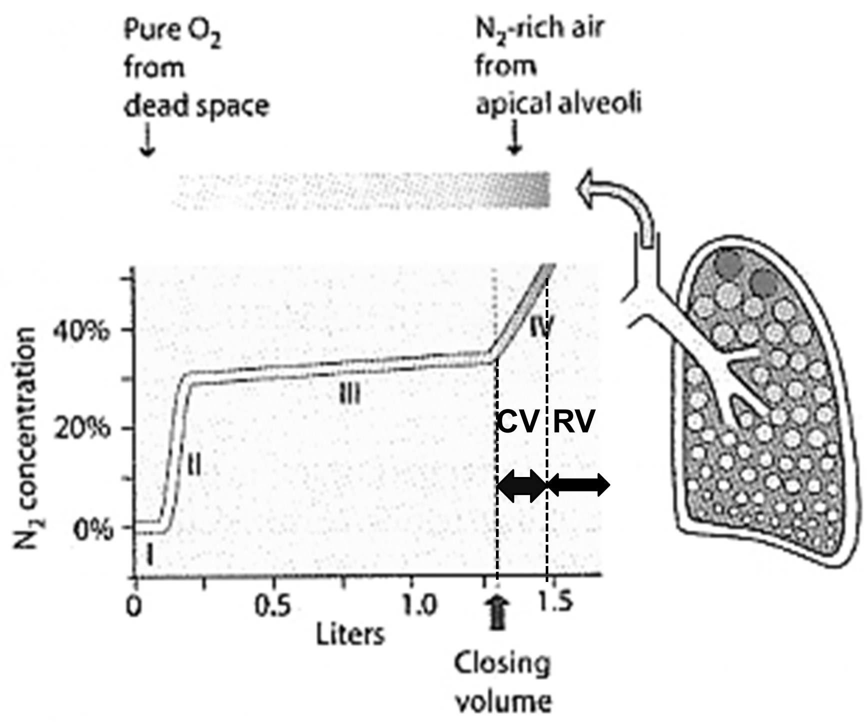
- lower lung has greater compliance *(the vol. change per unit pr. change)*
- lower lung has better ventilation *(the vol. change per unit time)*

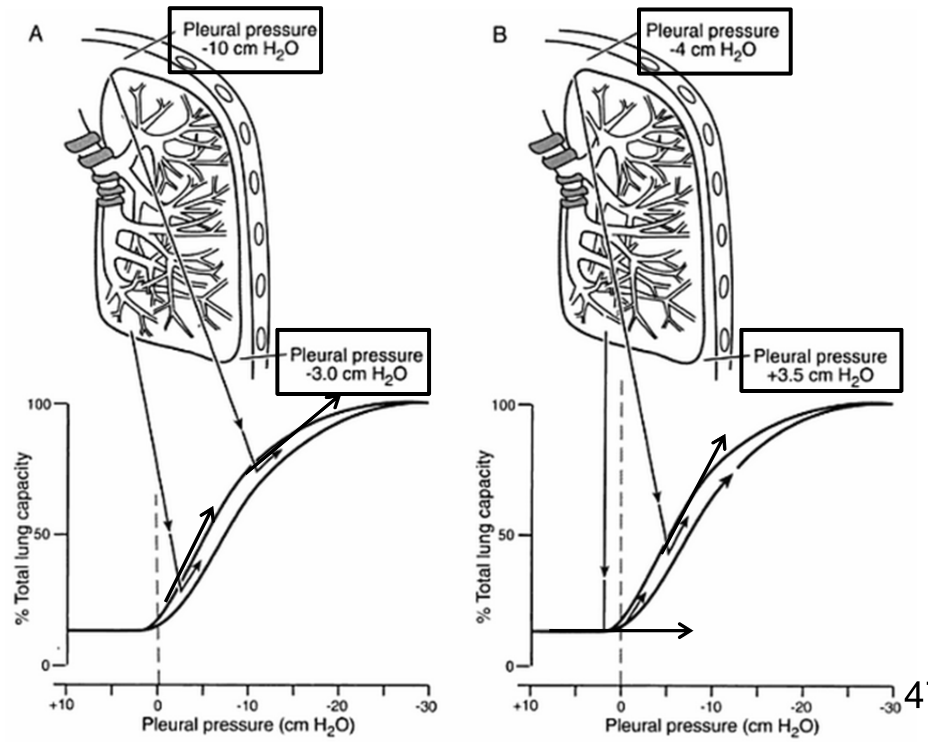




Closing Volume

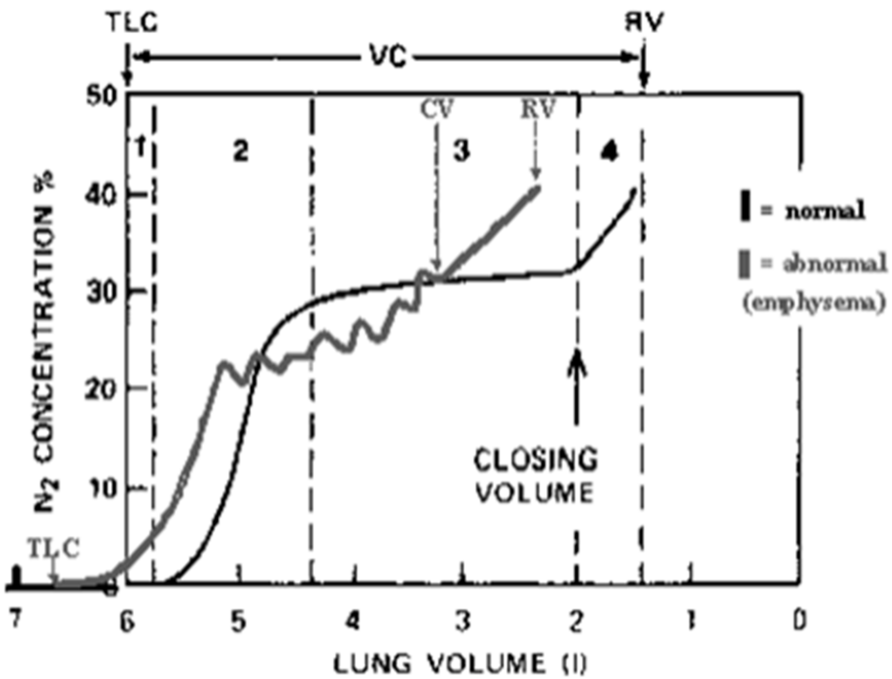
- In the single-breath N_2 washout measuring (Fowler's method),
  - Closing volume (CV) where an abrupt increase in N_2 concentration toward the end of expiration
- Signals closure of airways at the base of the lung
- Caused by preferential emptying of the apex

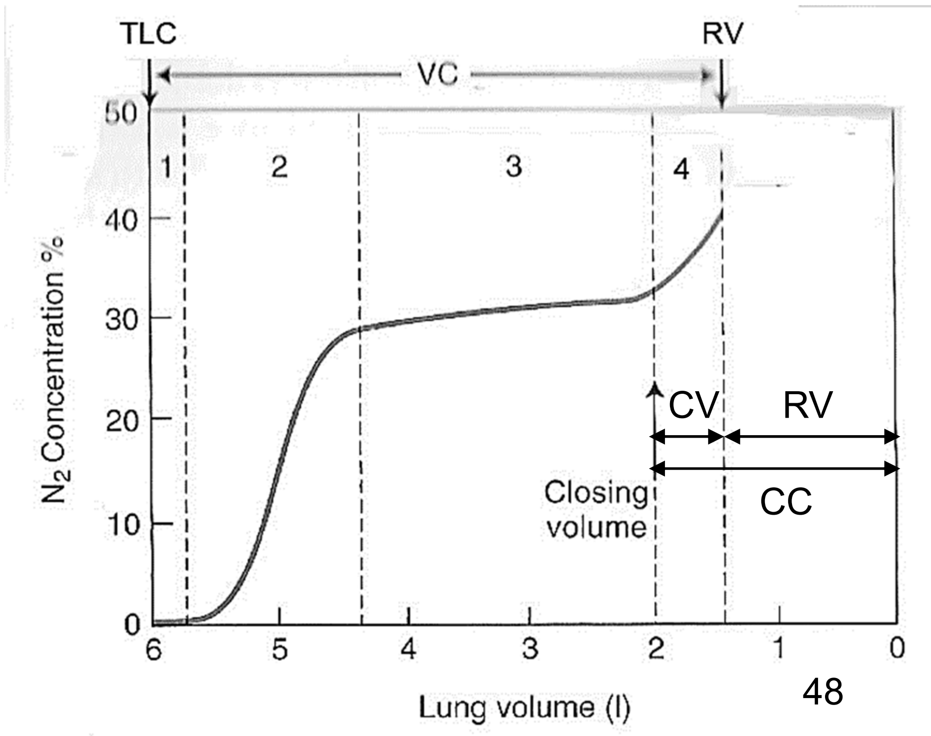




Closing Volume

- The CV increases with age, smoking, obstructive airways disease, and body position (supine > erect)
- Used to detect the disease in high-risk patients before clinical signs appear
- Closing capacity (CC) = CV + RV





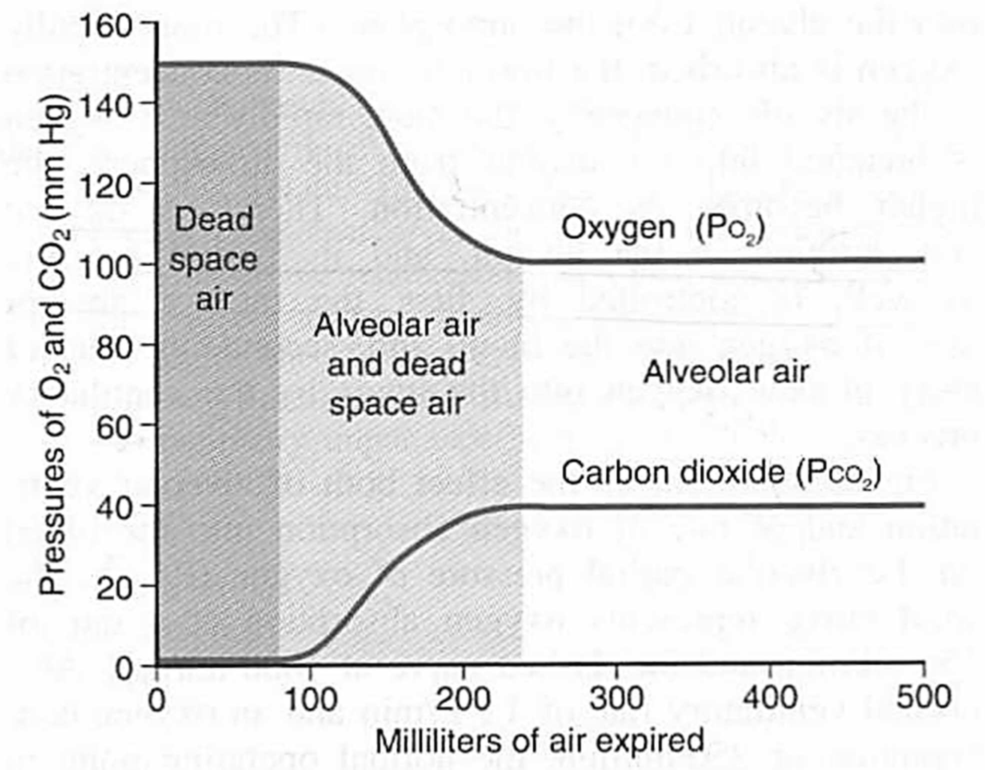
Partial Pressures of Gases in Various Parts

- In the alveoli, the percentage of oxygen decreases and CO_2 increases, changing the partial pressure of each

	Inspired air	Alveolar air
H_2O	Variable	47 mmHg
CO_2	000.3 mmHg	40 mmHg
O_2	159 mmHg	105 mmHg
N_2	601 mmHg	568 mmHg
Total pressure	760 mmHg	760 mmHg

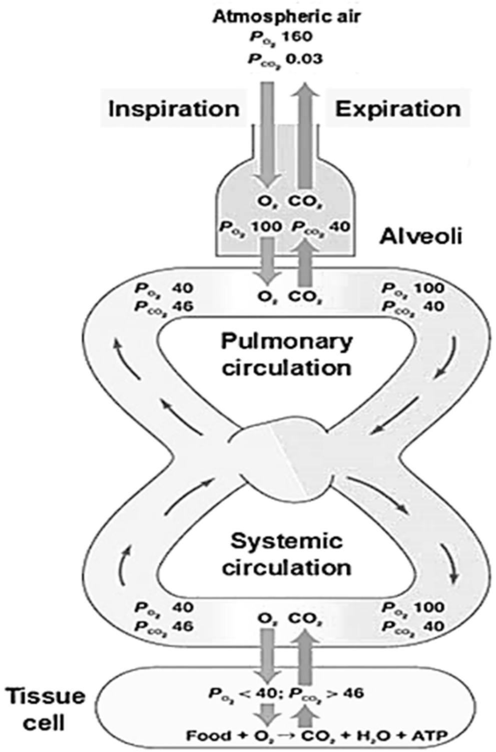
O_2 and CO_2 Concentrations in Exhaled Gas

- A good way to evaluate alveolar gas content in normal subjects is to examine gas coming out late in exhalation after the gas in the conducting airways has been cleared



Important

Overview of Po_2 and Pco_2



Ambient PO_2 = 160 mmHg = 760 x 0.21
PCO_2 = 0 mmHg

Inspired PO_2 = 150 mmHg
PCO_2 = 0 mmHg

$P_IO_2 = F_IO_2 \times (P_B - 47)$
$= 0.21 \times (760 - 47)$

Alveolar

P_AO_2 = 100 mmHg
P_ACO_2 = 40 mmHg

gas exchange ⇅

Mixed venous

End capillary

P_vO_2 = 40 mmHg
P_vCO_2 = 46 mmHg

P_aO_2 = 100 mmHg
P_aCO_2 = 40 mmHg

Pulmonary artery

Pulmonary vein

改變呼吸方式可改變
那種氣體的分壓?

1. 氧氣(Po_2)
2. 二氧化碳(Pco_2)

Hyper-, Hypo-ventilation & Hyperpnea

- Changes in alveolar ventilation ($\dot{V}_A$) cause reciprocal changes in alveolar P_{CO2}
- Hyperventilation: an increase in alveolar ventilation ($\dot{V}_A$) out of proportion to metabolism

→ ↓ P_{aCO2} (<37 mmHg)

- Hypoventilation: an decrease in alveolar ventilation ($\dot{V}_A$) out of proportion to metabolism

→ ↑ P_{aCO2} (>43 mmHg)

- Hyperpnea: an increase in alveolar ventilation ($\dot{V}_A$) is proportional to metabolism → ↔P_{aCO2} (40 mmHg)
  - ✓ increased breathing (usual ↑V_T)
- Tachypnea – increased frequency of respiration

跑步後很喘，如何快速回到正常的呼吸速率？

A) Hyperpnea
(深呼吸)

B) Tachypnea
(淺快呼吸)

Case	Tidal vol. (ml)	Freq. (/min)	Min. ventilation (ml/min)	Dead space (ml)	Alveolar ventilation (ml/min)
A	150	40	6000	150	(150-150)x40=0
B	500	12	6000	150	(500-150)x12=4200
C	1000	6	6000	150	(1000-150)x6=5100

A: Tachypnea B: Normal C: Hyperpnea

Respiration efficiency: hyperpnea > tachypnea

- NOT all inhaled air can be gas exchanged → dead space

Since dead space volume is fixed,

→ Increase frequency

→ Decrease tidal volume

→ Decrease alveolar ventilation

How to measure P_AO_2?

Alveolar Gas Equation

P_{AO2} = input O_2 – output O_2

= F_{IO2} (P_{atm} – P_{H2O}) – output O_2

= 0.21 (760 - 47) – output O_2

- ✓ F_{IO2}: fraction of O_2 in the inspired gas
- ✓ P_{atm}: barometric pressure
- ✓ P_{H2O}: water vapor pressure at body temp.

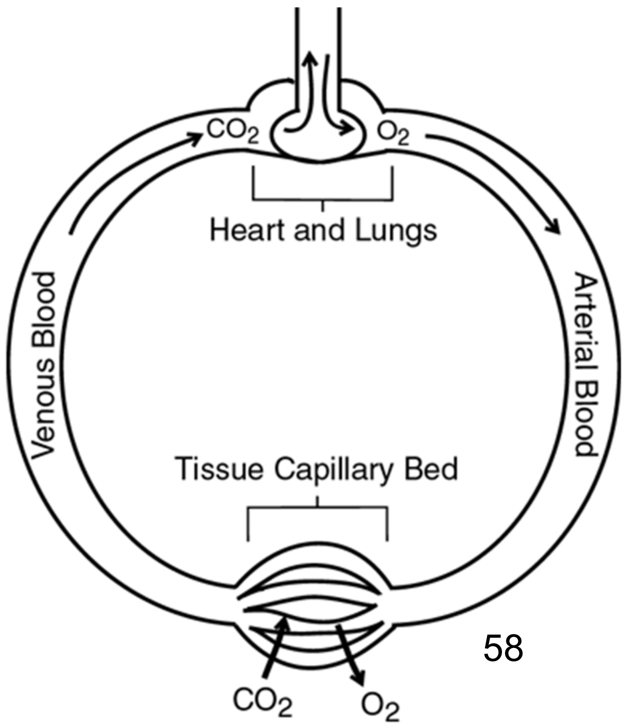
Respiratory Quotient (呼吸商)

- The ratio of metabolic CO_2 production to the O_2 consumption of the tissue ($\dot{V}co_2/\dot{V}o_2$)
  - ✓ As an indicator of energy source
- When carbohydrate is metabolized,

  $C_6H_{12}O_6 + 6O_2 \rightarrow 6CO_2 + 6H_2O$

  $$RQ = \frac{[CO_2]}{[O_2]} = \frac{6}{6} = 1$$
- Protein → 0.8
- Fat → 0.7
- RQ for the entire body varies;

  mean RQ ~ 0.83
- If RQ>1 → anaerobic metabolism



Alveolar Gas Equation

P_{AO2} = input O_2 – output O_2

= F_{IO2} (P_{atm} – P_{H2O}) – output O_2

= 0.21 (760 - 47) – output O_2

$$= 0.21\,(760 - 47) - \frac{P_{ACO2}}{R}$$

$$= 0.21\,(760 - 47) - \frac{P_{aCO2}}{R}$$

$$= 0.21\,(760 - 47) - \frac{40}{0.83}$$

~ 100 mmHg

✓ P_{ACO2} ~ P_{aCO2} = 40 mmHg

- Due to CO_2 diffuses very easily and quickly across the alveolar membrane → P_{ACO2} = P_{aCO2}

Reasons to Understand the Alveolar Gas Equation

- Understand gas exchange at the alveolar level
- Clinical utility of calculation of the A-a gradient for oxygen ($P_{AO2} – P_{aO2}$)
  - the difference in alveolar and arterial oxygen level
  - < 30 y/o: < 10 mmHg
  - > 30 y/o: (0.3 x age) mmHg

  OR

  - $\frac{\text{years of age}}{4}$ + 4 mmHg

Case Study

A 26 y/o female is found unresponsive and brought to the ER by ambulance. PE shows lacrimation (tearing), salivation, bradycardia and shallow breathing. ABG while breathing room air, pH 7.20 (normal 7.40), P_{CO2} = 60 mmHg, P_{O2} = 70 mmHg. Is this patient's low Pa_{O2} due to hypoventilation or lung pathology?

Ans:

$$P_{AO2} = F_{IO2}\,(P_{atm} - P_{H2O}) - \frac{P_{ACO2}}{R}$$

$$= 0.21\,(760\text{-}47) - \frac{60}{0.83}$$

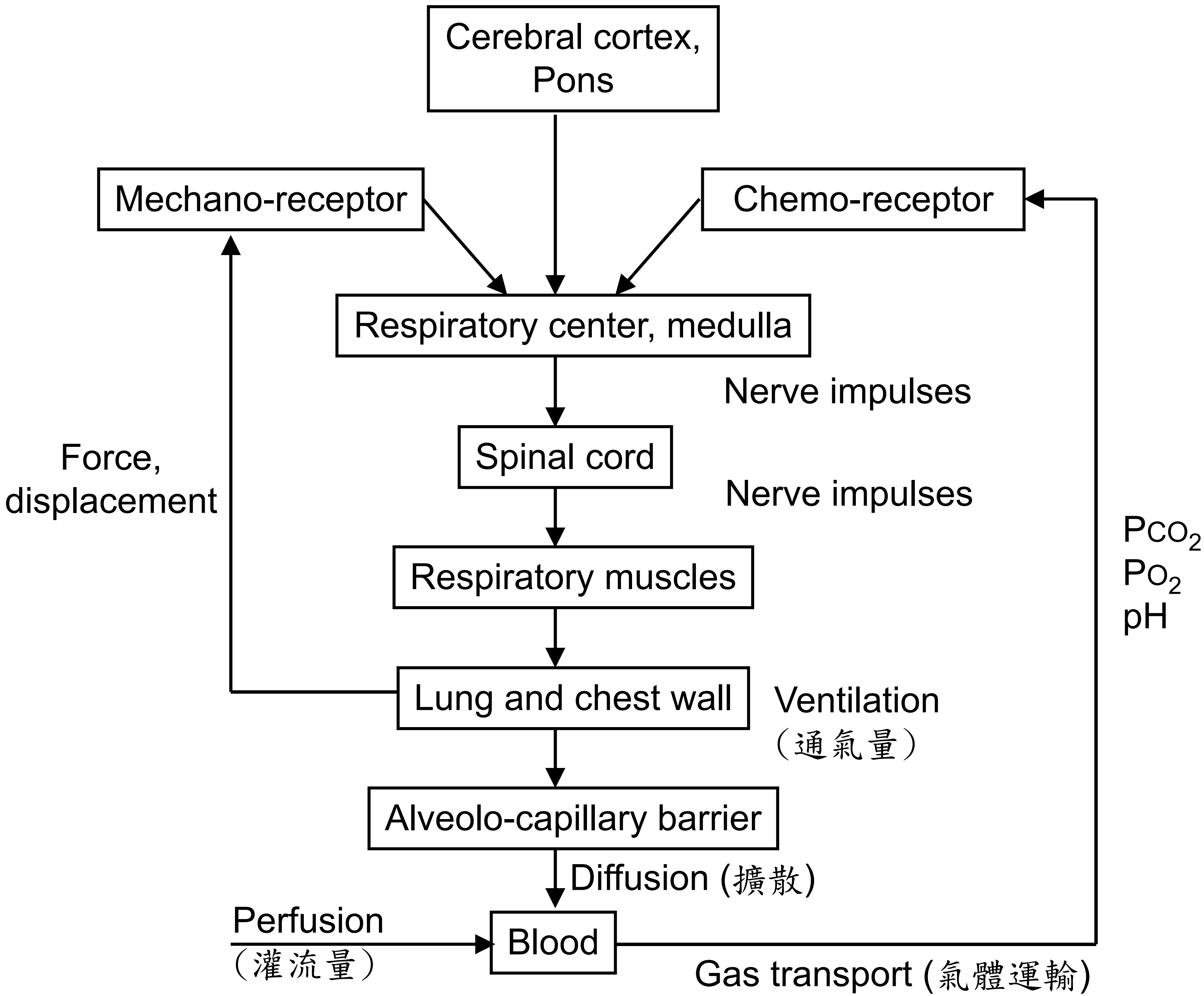
$$= 77.4 \text{ mmHg}$$

A-a O_2 diff = 77.4 – 70 = 7.4 (<10 mmHg)

→ This patient's low Pa_{O2} is due to hypoventilation

Outline

- Background
- Structure and function
- Ventilation
- Perfusion（灌流量）and ventilation/perfusion ratio
- Static/Dynamic respiratory mechanics
- Diffusion and gas transport
- Neural control of respiration
- Chemical control of respiration
- Acid-base balance
- Examples: exercise and high altitude adaptation

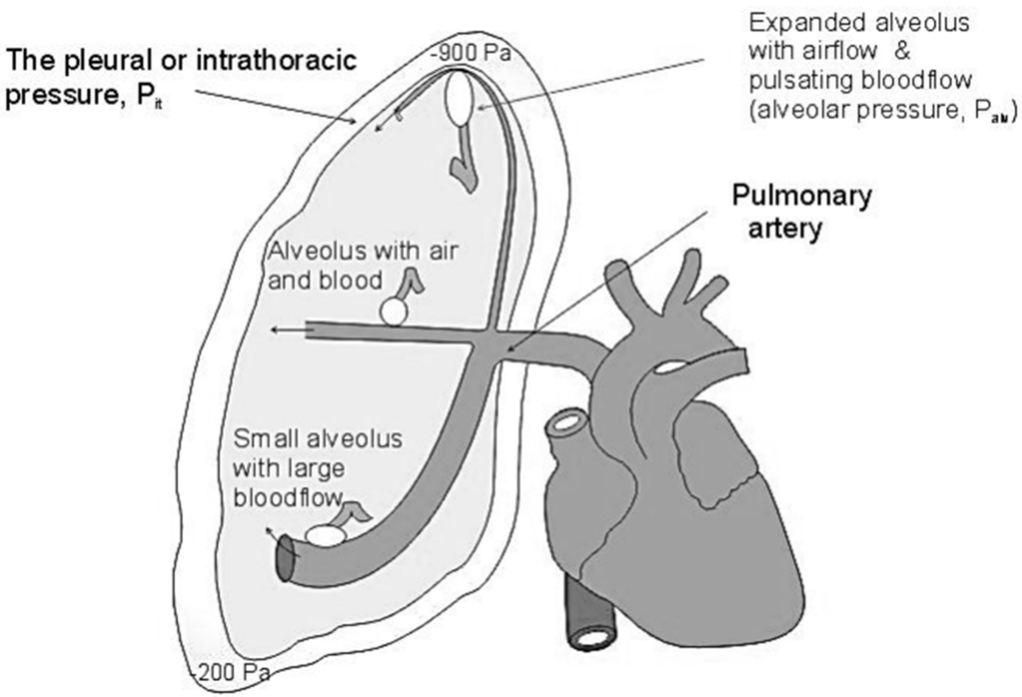


Cerebral cortex, Pons
Mechano-receptor
Chemo-receptor
Respiratory center, medulla
Nerve impulses
Spinal cord
Nerve impulses
Force, displacement
Respiratory muscles
P_{CO_2}
P_{O_2}
pH
Lung and chest wall
Ventilation (通氣量)
Alveolo-capillary barrier
Diffusion (擴散)
Perfusion (灌流量)
Blood
Gas transport (氣體運輸)

Perfusion（灌流量）

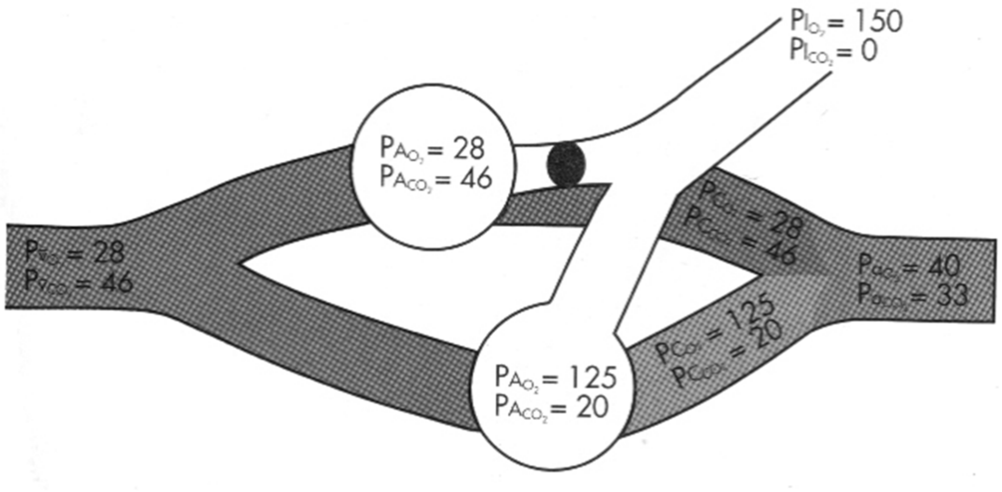
- Perfusion (Q): blood flow through the lung
  - ✓ The distribution of blood flow is largely due to the effects of gravity

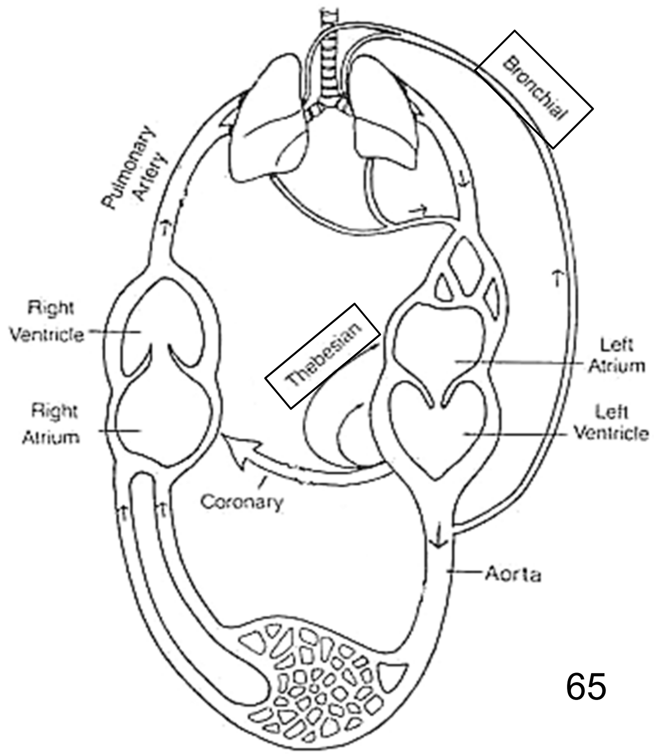
    i.e. the effect of hydrostatic pressure



Shunt（分流）

- Shunt: blood without gas exchange with alveoli
  - ✓ Intrapulmonary shunts: blood perfuses alveoli but is not ventilated
  - ✓ Anatomical shunts
    - Bronchial circulation enters the pulmonary veins
    - Coronary circulation enters LV via thebesian veins





Shunt Equation

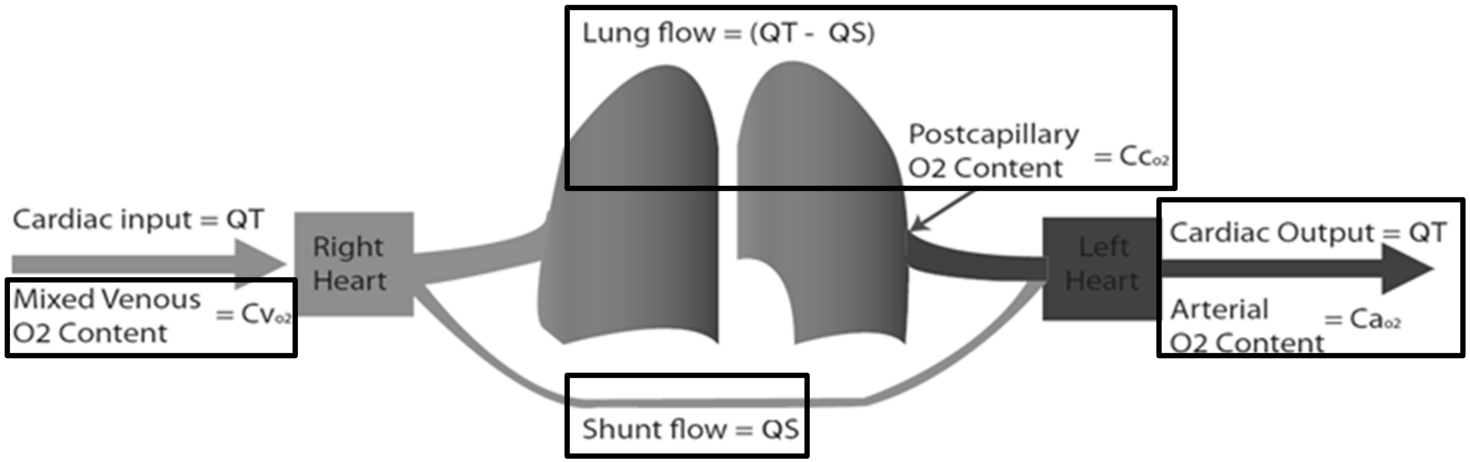
- Assumption: total oxygen carried by the arterial blood may be calculated by adding the oxygen contents of the blood that passes the lungs and the shunted blood
- Cardiac output x Arterial O_2 content

= Lung flow x Post-cap O_2 content + Shunt flow x Venous O_2 content

$$Q_T \times Cao_2 = (Q_T - Q_S) \times Cco_2 + (Q_S \times Cvo_2)$$

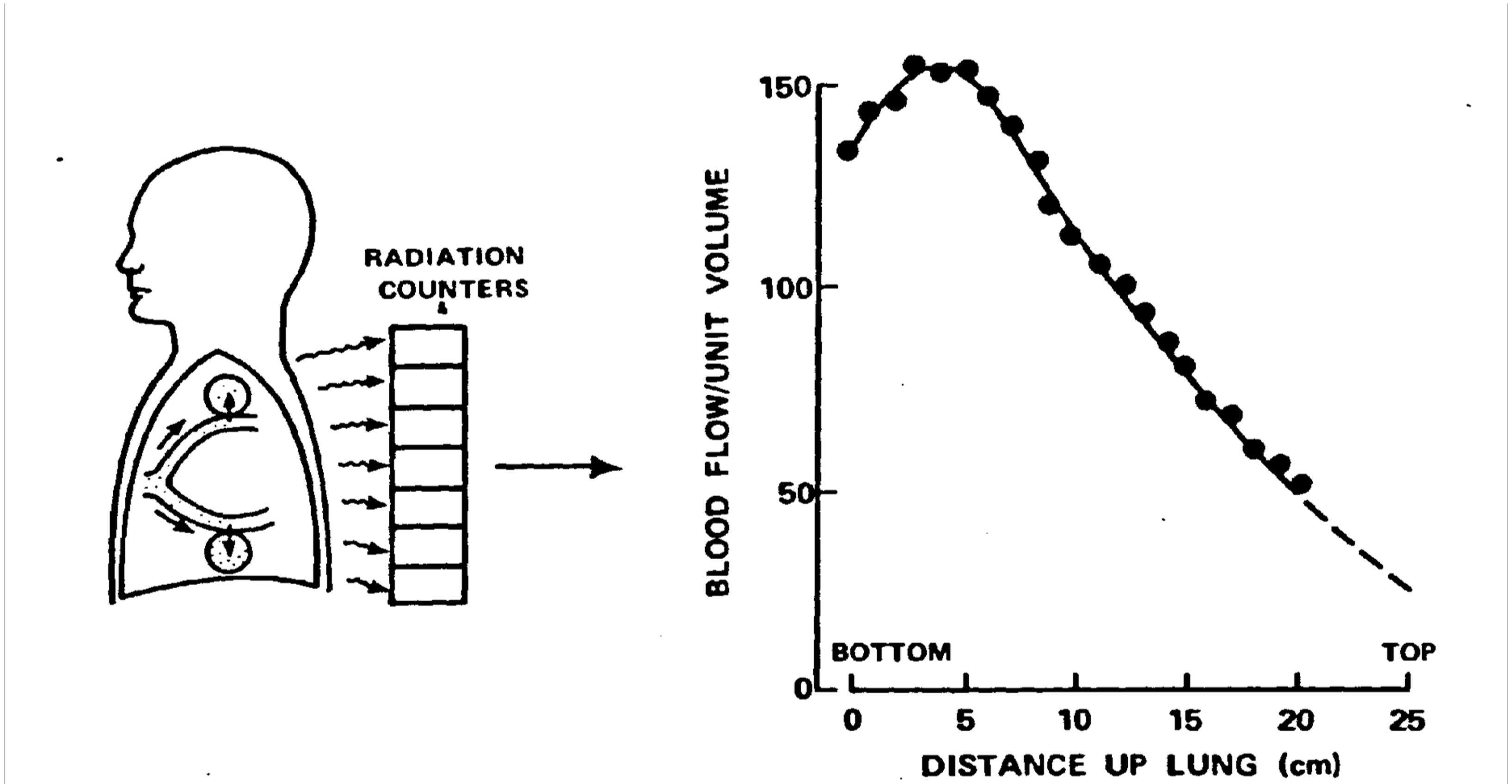
- → $\dfrac{Q_S}{Q_T} = \dfrac{Cco_2 - Cao_2}{Cco_2 - Cvo_2}$

- Cco_2 : Post-capillary O_2 content
- Cao_2 : Arterial O_2 content
- Cvo_2 : Venous O_2 content



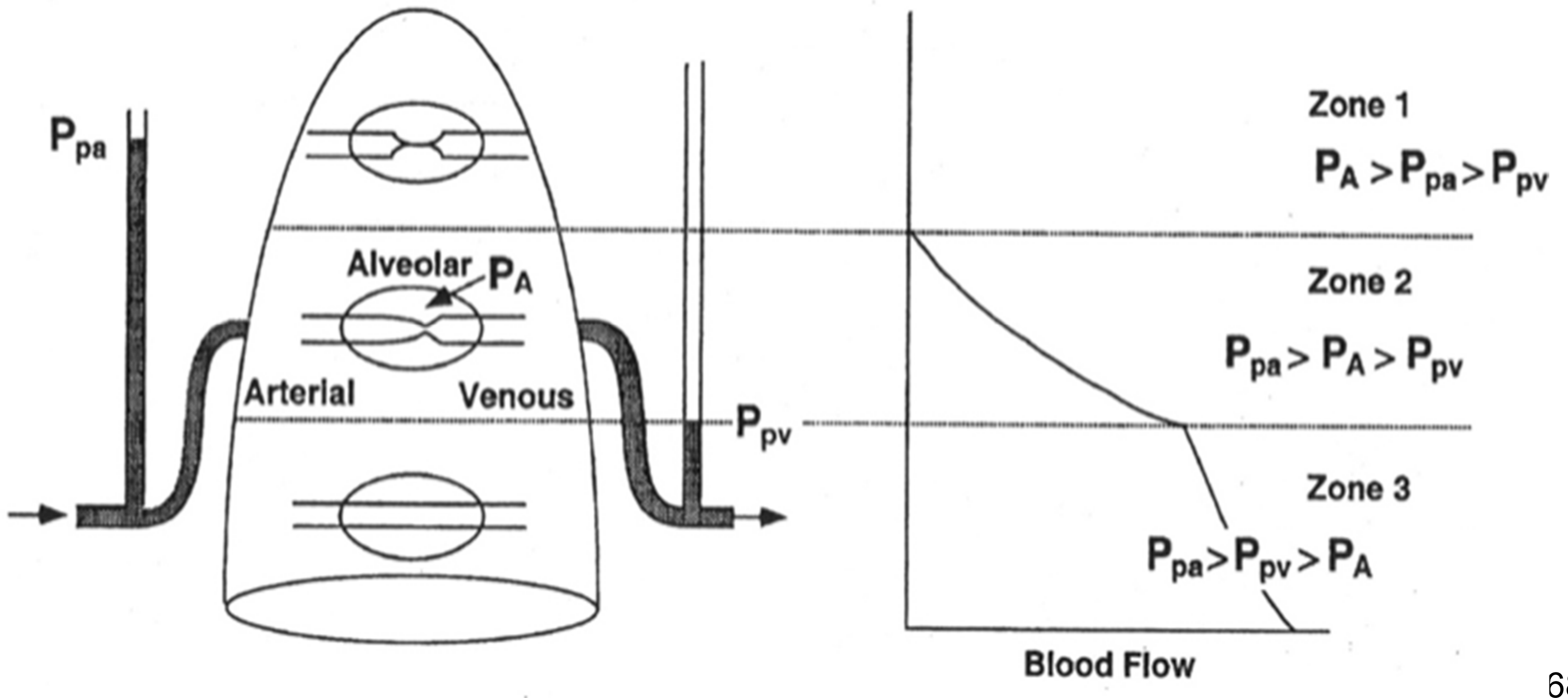
Uneven Perfusion in Upright Position

In the upright position, blood flow is maximal at the lung bases, decreasing linearly to the apices



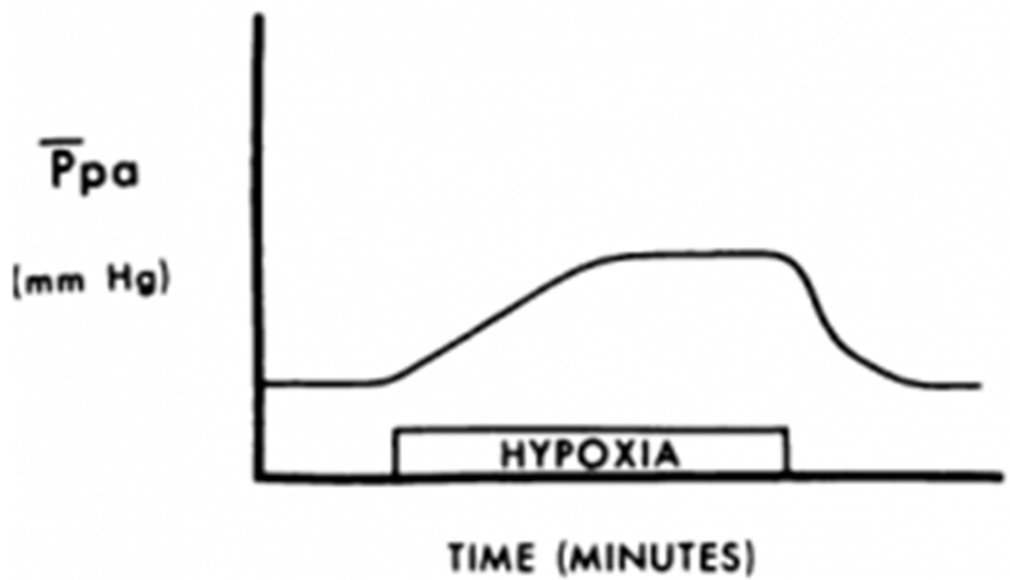
Zone Model

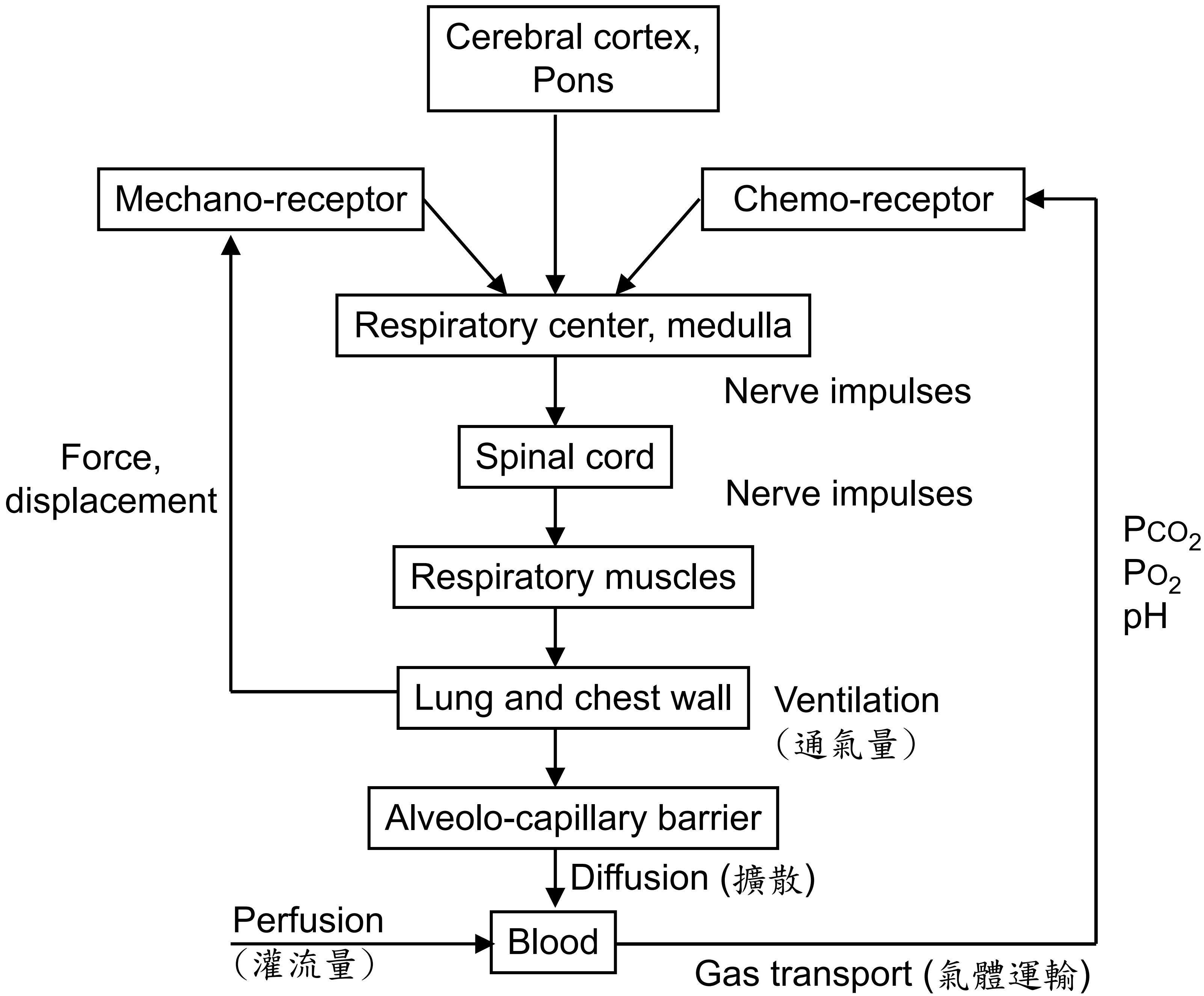
Flow is a function of vertical height and is dependent on the relationship between alveolar pressure (P_A) and vascular pressure (P_{pa}, P_{pv})



Hypoxic Pulmonary Vasoconstriction

- Vasoconstriction occurs when alveolar Po_2 <70 mmHg
- Physiological roles:
  - ✓ Directs blood flow away from poorly ventilated areas of the diseased lung in the adult
  - ✓ Critical at birth in the transition from placental to air breathing

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Nerve impulses
Spinal cord
Nerve impulses
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Respiratory muscles
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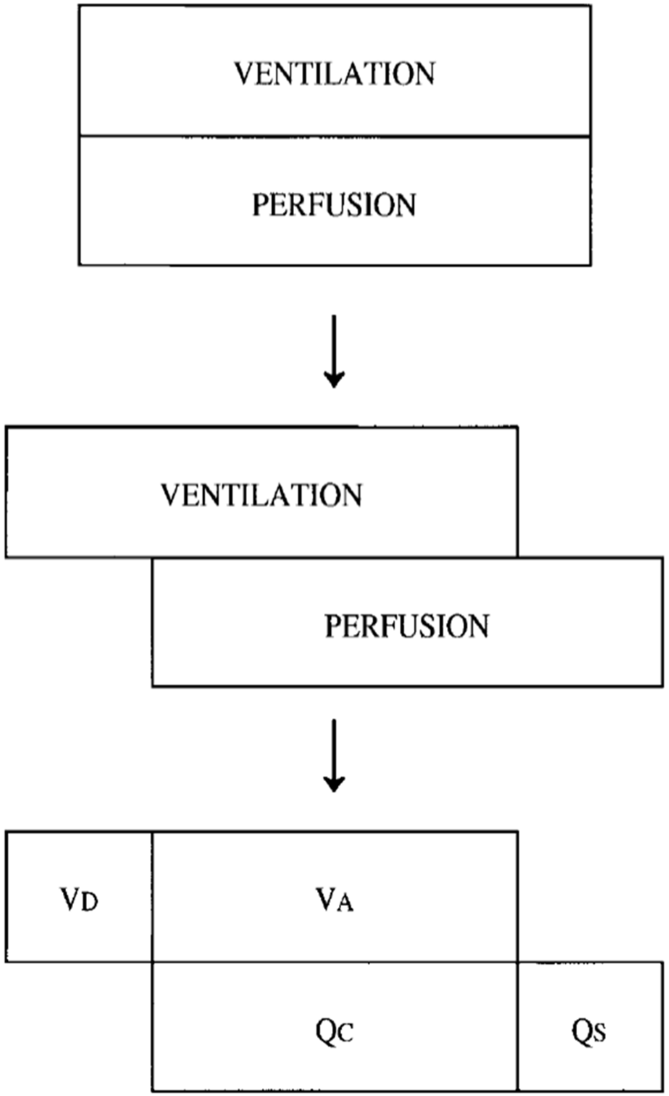
P_{O_2}
pH
Lung and chest wall
Ventilation
(通氣量)
Alveolo-capillary barrier
Diffusion (擴散)
Perfusion
(灌流量)
Blood
Gas transport (氣體運輸)

Matching of Ventilation & Perfusion



Perfect matching

→ $\dot{V}/Q=1$

Mismatching of $\dot{V}/Q$

$\dot{V} = \dot{V}_A + \dot{V}_D$

$\dot{V}_A$: alveolar ventilation

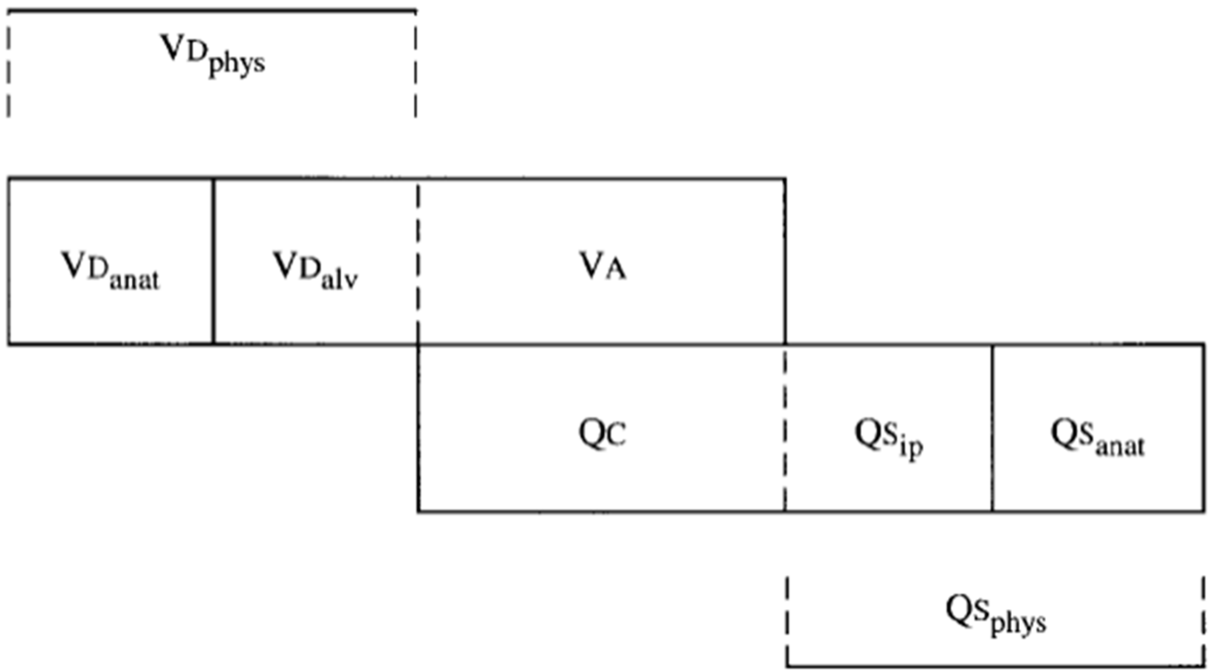
$\dot{V}_D$: dead-space ventilation

$Q = Q_C + Q_S$

Q_C: capillary flow

Q_S: shunt flow

Mis-matching of Ventilation & Perfusion



$\dot{V}_D{}^{phys} = \dot{V}_D{}^{anat} + \dot{V}_D{}^{alv}$

$\dot{V}_D{}^{phys}$: physiological $\dot{V}_D$

$\dot{V}_D{}^{anat}$: anatomic $\dot{V}_D$

$\dot{V}_D{}^{alv}$: alveolar $\dot{V}_D$

$Q_S{}^{phys} = Q_S{}^{ip} + Q_S{}^{anat}$

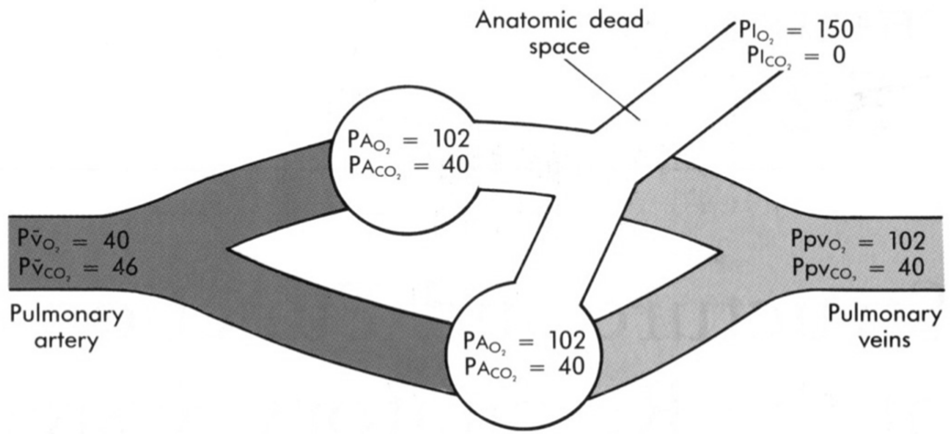
$Q_S{}^{phys}$: physiological shunt

$Q_S{}^{ip}$: intrapulmonary shunt

$Q_S{}^{anat}$: anatomical shunt

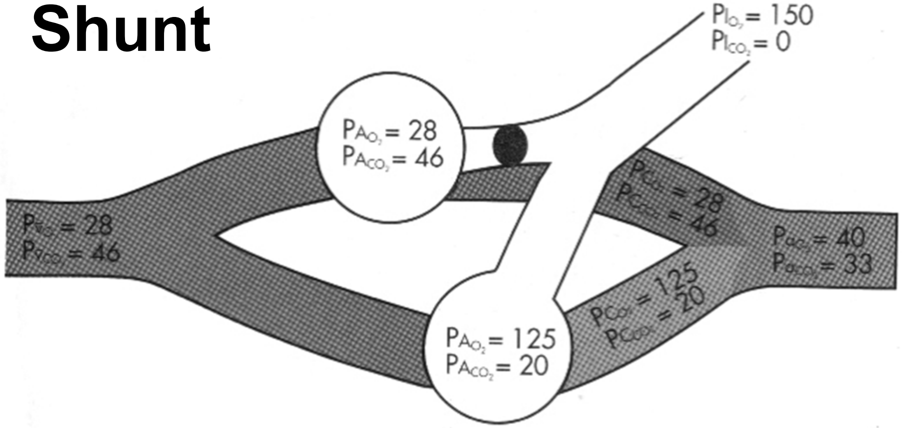
$\dot{V}/Q$ 受什麼影響?

Matching of Ventilation & Perfusion

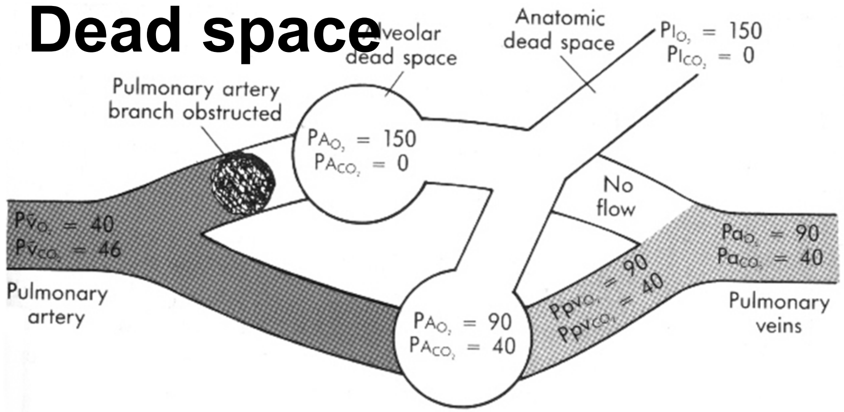


$\dot{V}/Q \sim 0.8$

Shunt



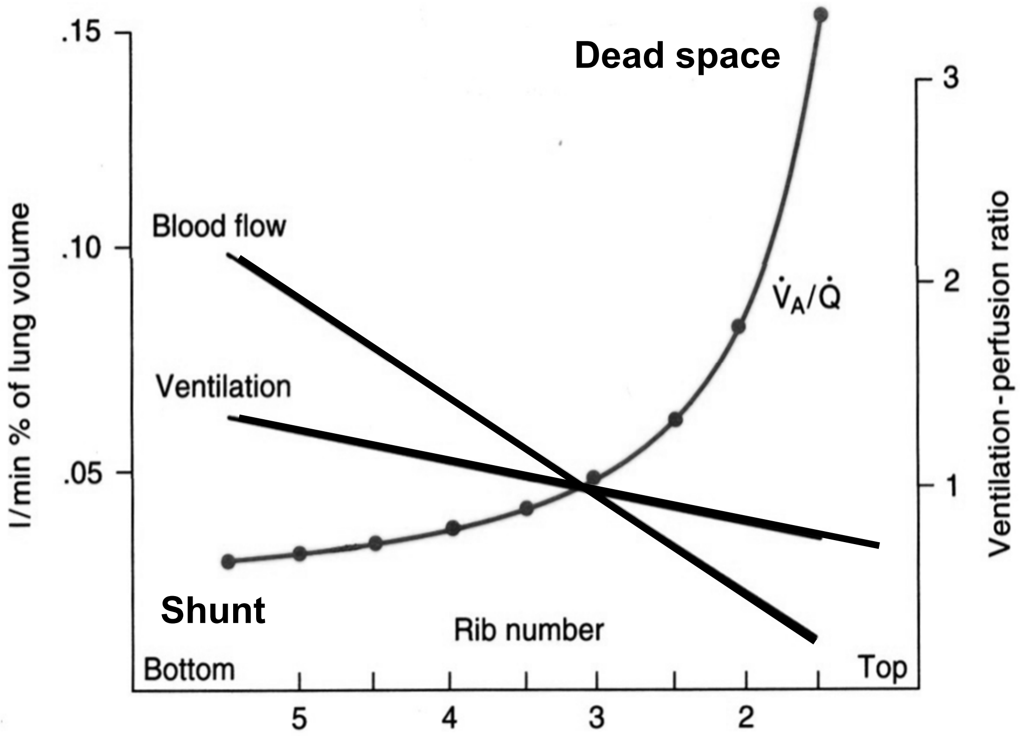
Dead space

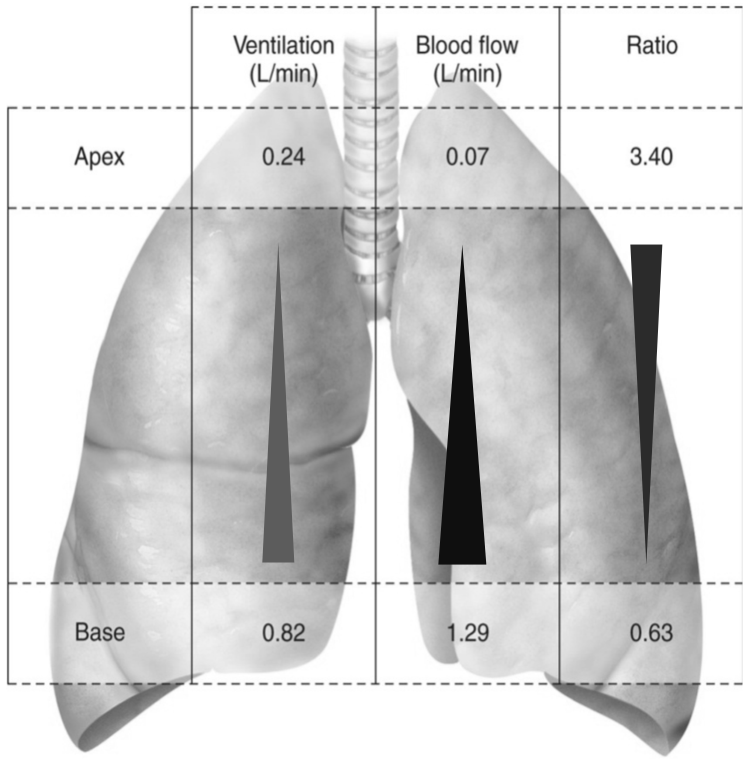


$\dot{V}/Q \downarrow$ $\dot{V}/Q \uparrow$

Distribution of $\dot{V}$ and Q Within the Lung in the Upright Position

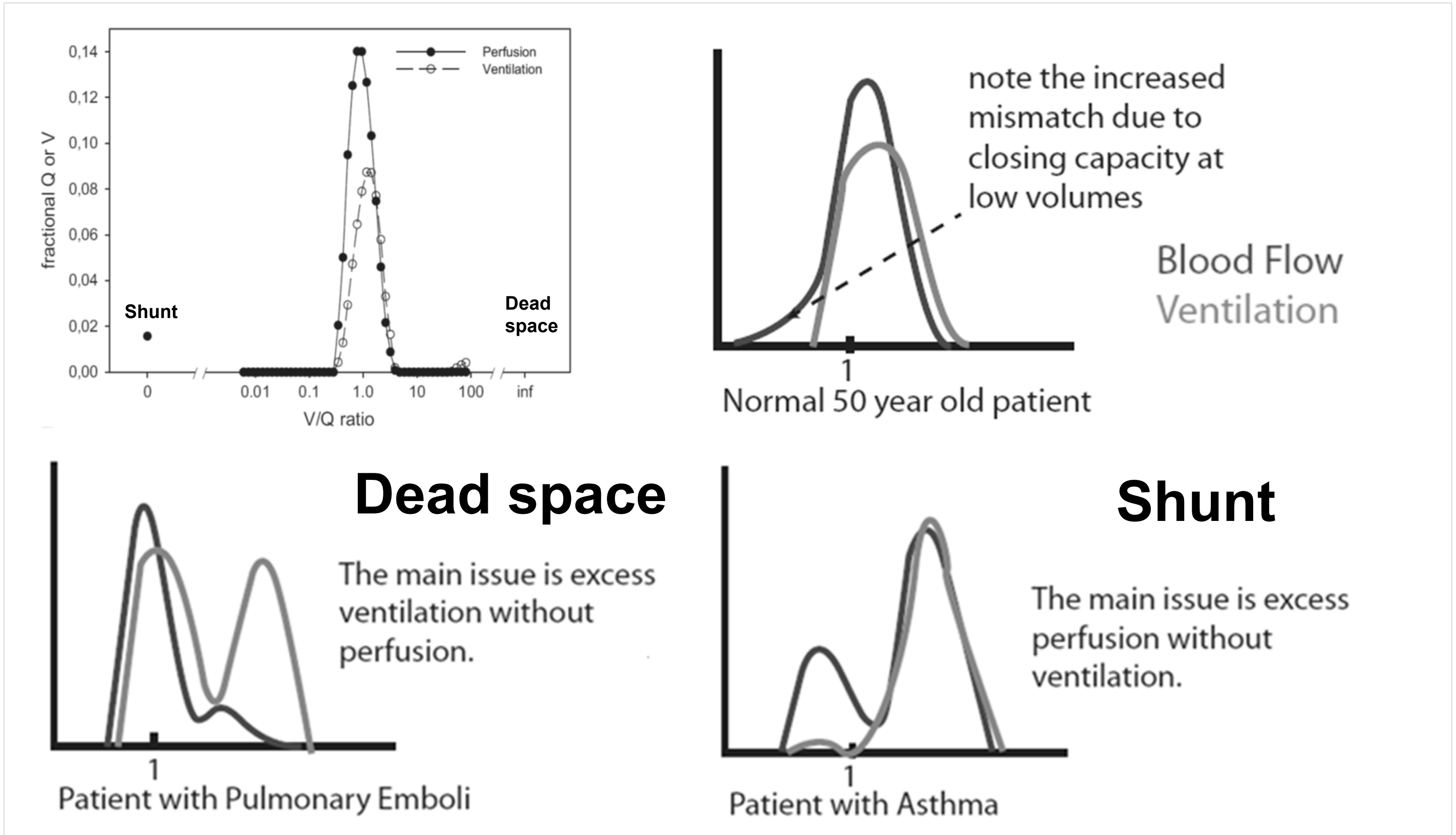
- $\dot{V}$ ↓ from base to apex of lung
- Q ↓↓from base to apex of lung
- → $\dot{V}$ /Q ↑ from base to apex of lung





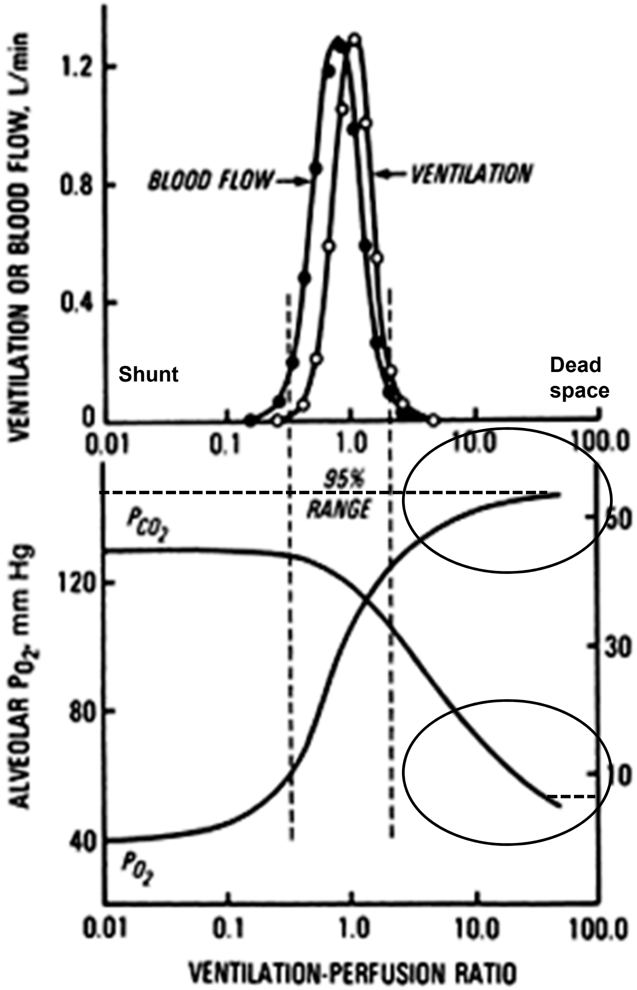
Distribution of $\dot{V}/Q$ Ratio

The distributions of both ventilation and blood flow are narrow and symmetric



$\dot{V}/Q$ 如何影響氣體的分壓?

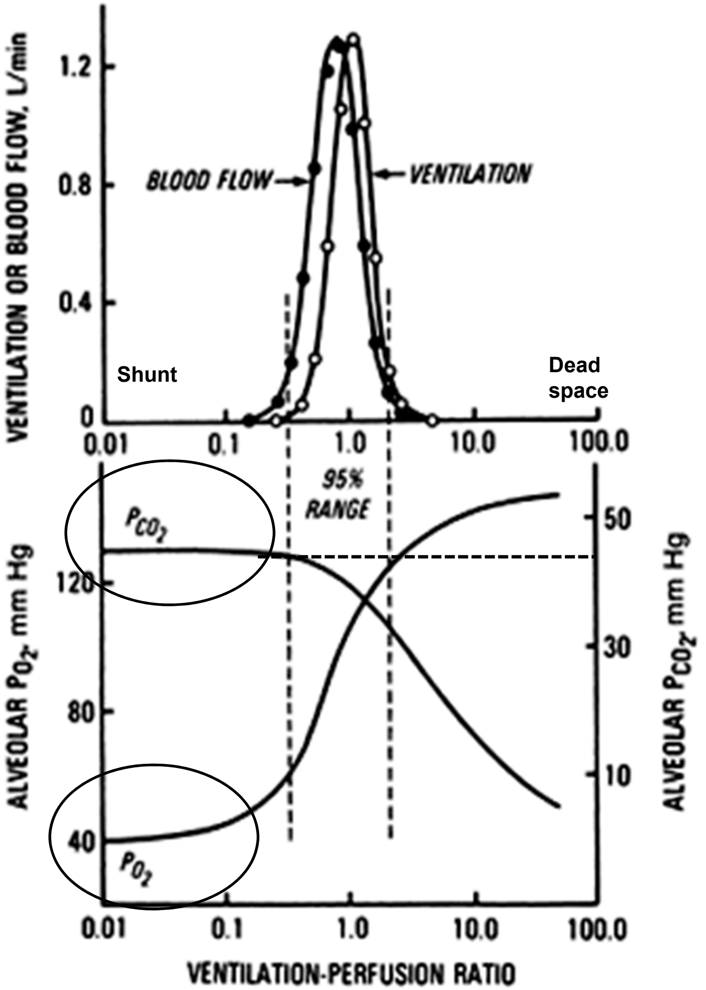
Effects of $\dot{V}/Q$ Ratio on P_Ao_2 & P_Aco_2



- Different $\dot{V}/Q$ ratios result in different P_AO_2 and P_Aco_2
  - ✓ Higher $\dot{V}/Q$
  - ✓ normal $\dot{V}/Q$ + dead space
  - →end capillary alveolar P_ACO_2 decrease

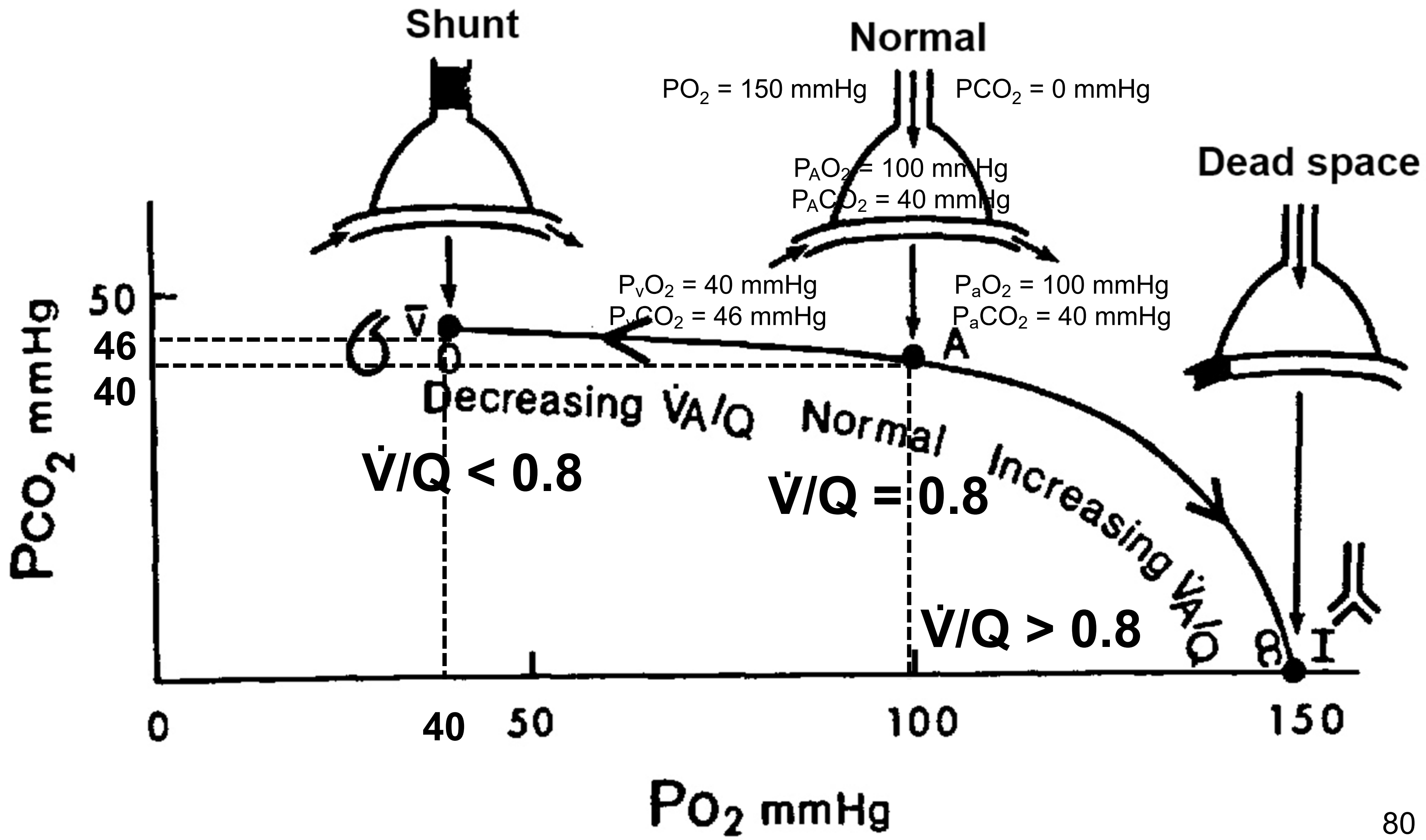
BUT arterial P_{aCO2} increase

Effects of $\dot{V}/Q$ Ratio on $P_{A}o_2$ & $P_{A}co_2$



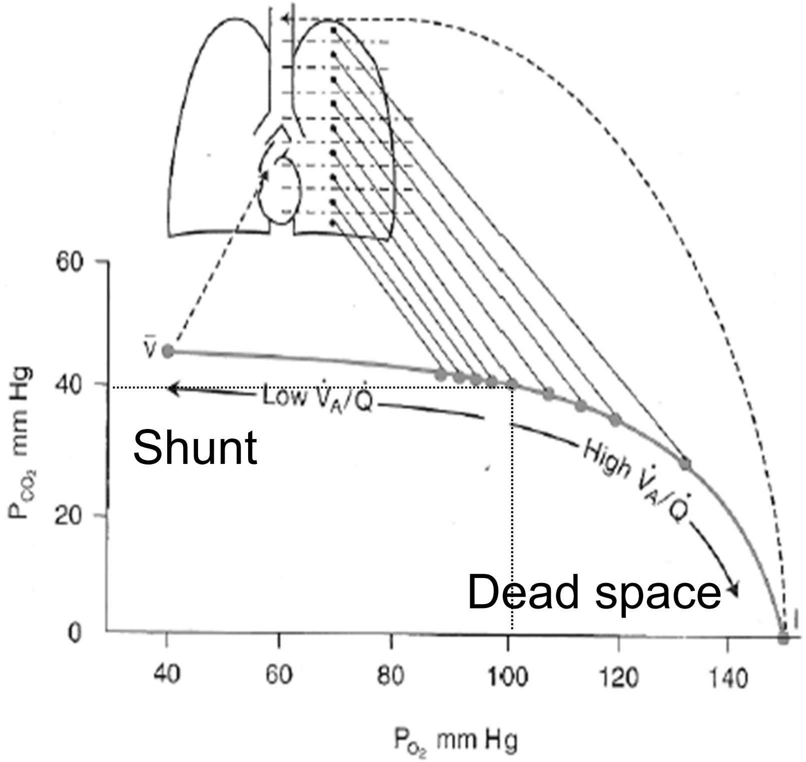
- Different $\dot{V}/Q$ ratios result in different $P_{A}o_2$ and $P_{A}co_2$
  - ✓ Lower $\dot{V}/Q$
  - ✓ normal $\dot{V}/Q$ + Shunt
  - → Higher alveolar $P_{A}co_2$

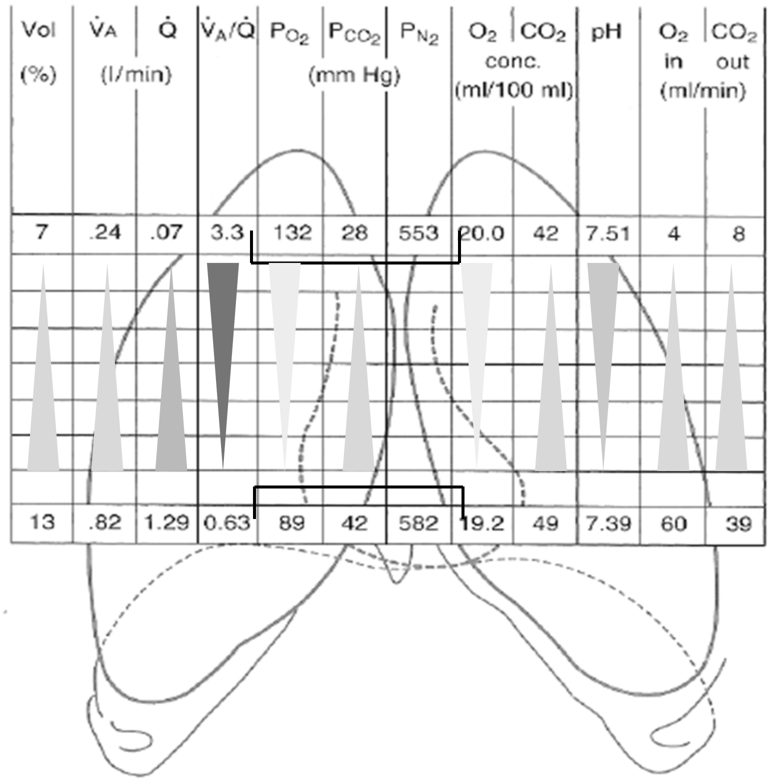
$\dot{V}/Q$ v.s. Po_2 & Pco_2



$\dot{V}$/Q Inequality of Normal Lung in the Upright Position

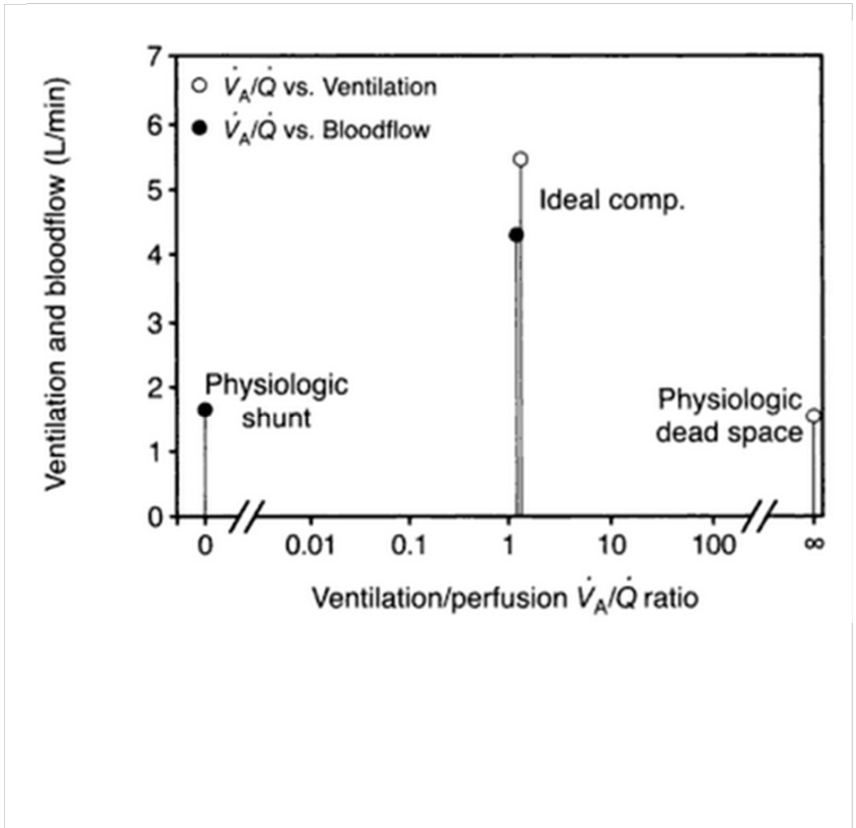
- High $\dot{V}$/Q ratio at the apex → high Po_2 and low Pco_2

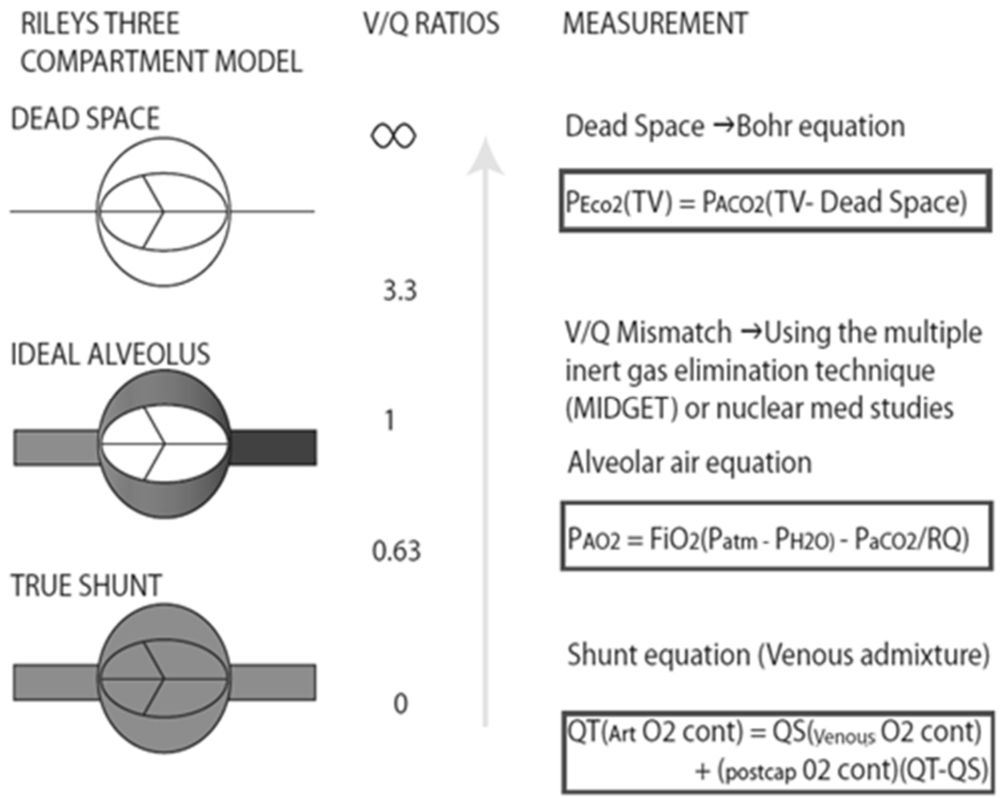




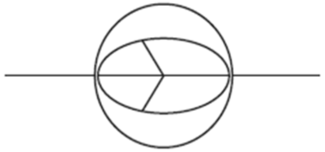
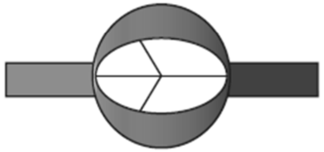
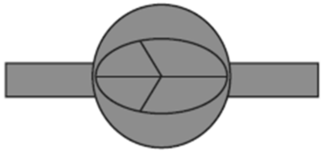
Vol (%)	$\dot{V}_A$ (l/min)	$\dot{Q}$	$\dot{V}_A/\dot{Q}$	P_{O_2} (mm Hg)	P_{CO_2}	P_{N_2}	O_2 conc. (ml/100 ml)	CO_2	pH	O_2 in (ml/min)	CO_2 out
7	.24	.07	3.3	132	28	553	20.0	42	7.51	4	8
13	.82	1.29	0.63	89	42	582	19.2	49	7.39	60	39

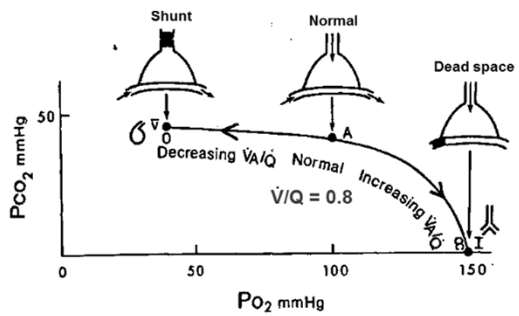
Riley's Three Compartment Model

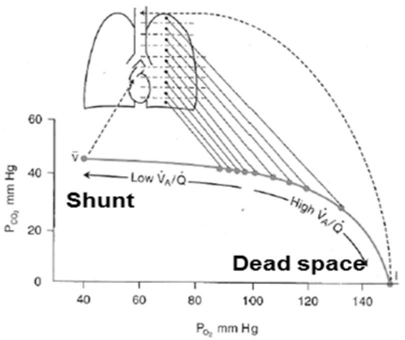




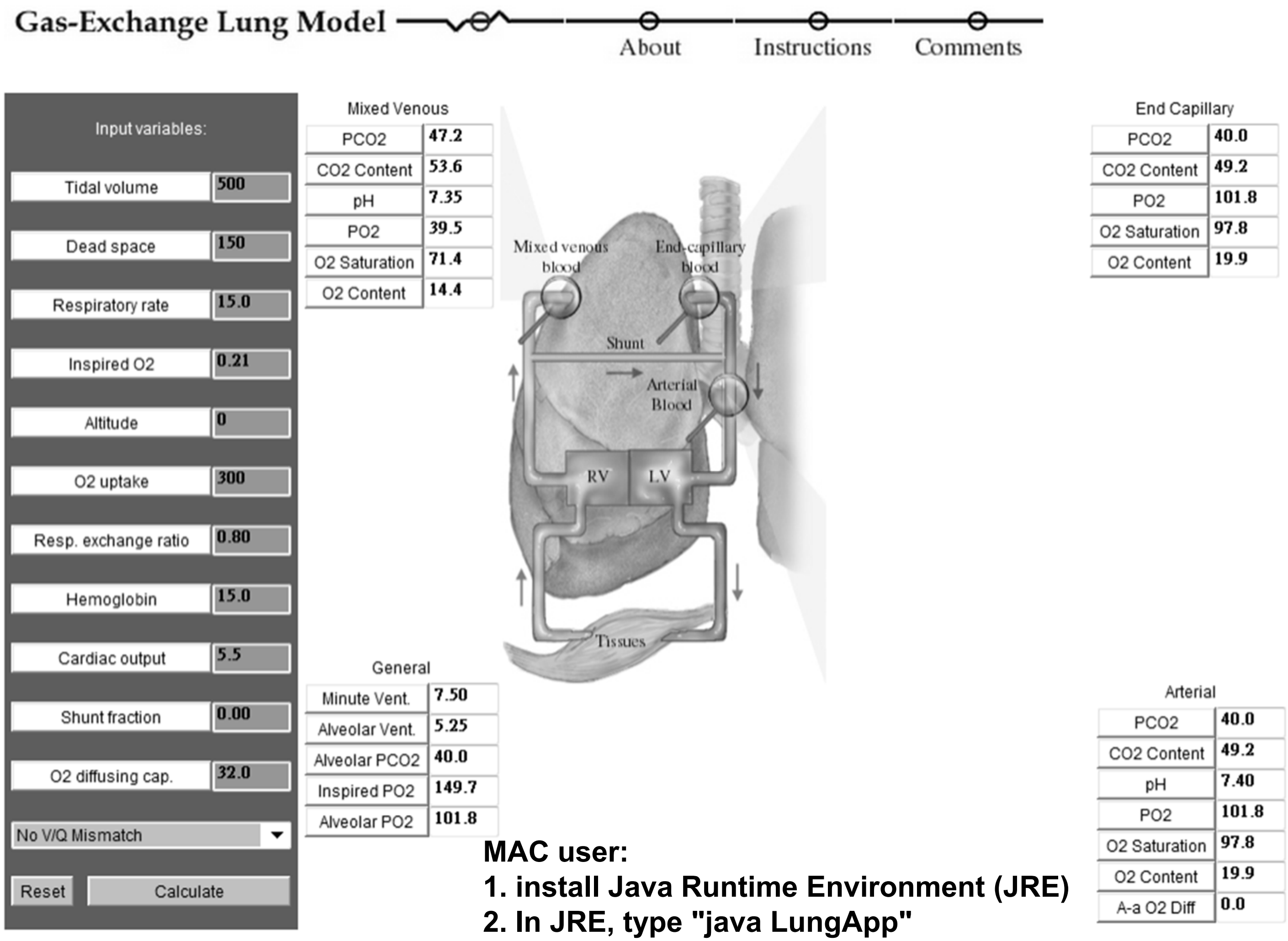
Riley’s Three Compartment Model

RILEYS THREE COMPARTMENT MODEL	V/Q RATIOS	ALVEOLAR AIR	CONSEQUENCE	TREATMENT
DEAD SPACE 	∞	Alveolar air approaches inspired air concentrations (no exchange wasted air) P02 = 149 CO2 = 0	Decreased perfusion leads wasted ventilation therefore decreased minute alveolar ventilation & primarily to increased blood CO2	Increased tidal volumes will reduce the effect of dead space (note that Alveolar Vent = TV - PDS)
	3.3			
IDEAL ALVEOLUS 	1	Alveolar air equals concentration of postcap blood due to ideal exchange P02 = 104 CO2 = 40	V/Q scatter leads to decreased PaO2 because a majority of mismatch flow is at ratios < 1 and a small drop is acentuated by the point on the Hb dissociation curve	Increased FiO2 will improve oxygenation unless the V/Q ratio is 0 (true shunt). High FiO2 will remove the V/Q scatter effect.
	0.63			
TRUE SHUNT 	0	Alveolar air approaches mixed venous concentrations (no exchange wasted blood) P02 = 40 CO2 = 46	Shunt leads to both ↑CO2 and ↓O2 but the decrease in PO2 is more pronounced because it is on the flat of the dissociation curve and the CO2 dissociation is near linear	Improved recruitment may work unless the shunt is extra-pulmonary. ↑FiO2 is decreasingly effective in true shunts > 30%





Gas Exchange Computer Lab



MAC user:
1. install Java Runtime Environment (JRE)
2. In JRE, type "java LungApp"

*Hint: the discussion notes

Outline

- Background
- Structure and function
- Ventilation
- Perfusion and ventilation/perfusion ratio
- Static/Dynamic respiratory mechanics (呼吸力學)
- Diffusion and gas transport
- Neural control of respiration
- Chemical control of respiration
- Acid-base balance
- Examples: exercise and high altitude adaptation

Key Points

- General concepts and terminology
- Mechanical properties
  - 1. Compliance
  - 2. Resistance
  - 3. Pressure-volume (P-V) curve of the lungs
  - 4. Lung-chest wall coupling

General Concepts and Terminology

- P_{total} = resistive Pr + elastic Pr = $\dot{V}R + \frac{\Delta V}{C}$
  - ✓ In spontaneous breathing, $P_{total} = P_{muscle}$
  - ✓ In mechanical ventilation, $P_{muscle} = 0$, P_{total} is driven by ventilator
- *Active* ($P_{muscle} > 0$) or *passive* ($P_{muscle} = 0$)
- *Static* ($\dot{V} = 0$) or *dynamic* ($\dot{V} <> 0$)
- Transmural pressure (跨壁壓): pressure difference from the inside to the outside
- Atmospheric pressure is considered = 0,

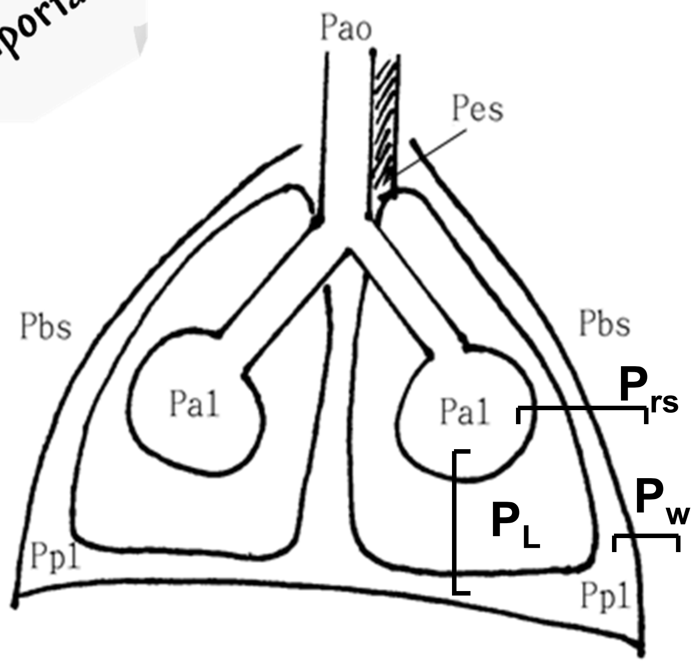
  → positive pressure meaning the value greater than atmospheric pressure, vice versa

General Concepts and Terminology

- P_{total} = resistive Pr + elastic Pr = $\dot{V}R + \frac{\Delta V}{C}$
- Under static conditions,

  transmural pressure = elastic recoil pressure of the compartment
- Static properties (when flow=0) mean lung elastic recoil
  - ✓ Elastic properties of the lung tissue itself
  - ✓ Surface tension

Important



$$P_L = P_{al} - P_{pl} \qquad (1)$$

$$P_w = P_{pl} - P_{bs} \qquad (2)$$

$$(1) + (2)$$

$$P_{rs} = P_L + P_w = P_{al} - P_{bs}$$

a) $P_{bs} = 0 \rightarrow P_w = P_{pl} = P_{es}$

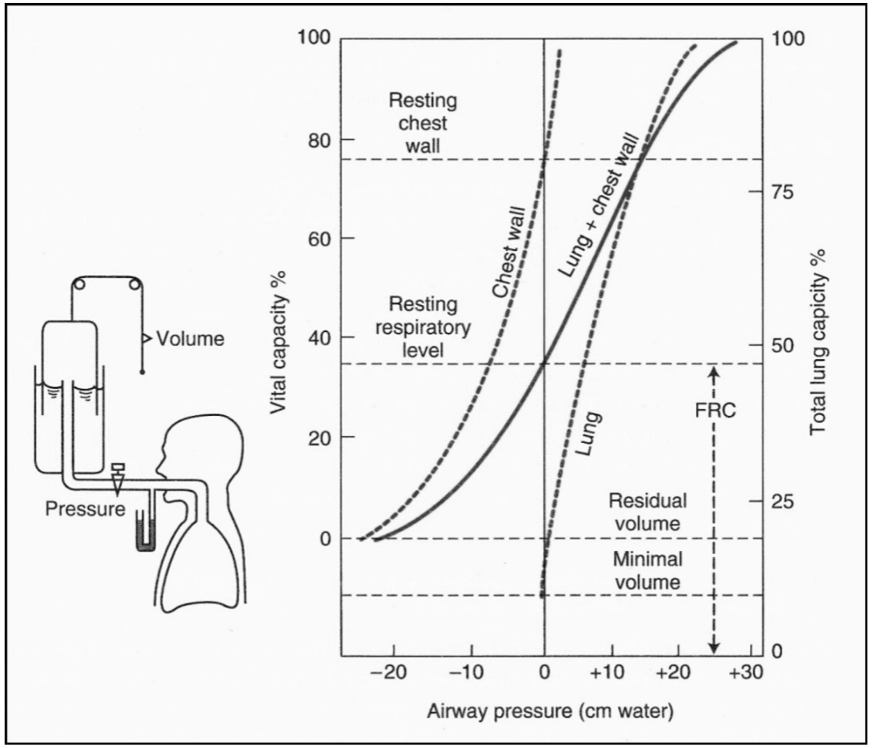
$$P_{rs} = P_{al}$$

P_L: transpulmonary Pr. (跨肺壓)
P_{al}: alveolar Pr.
P_{pl}: intrapleural Pr.
P_w: trans-chest wall Pr. (跨胸壁壓)
P_{bs}: body surface Pr.
P_{rs}: respiratory sys. Pr.
P_{ao}: airway opening Pr.
P_{es}: esophageal Pr.

b) $P_{ao} = \dot{V}R_{aw} + P_{al}$

When flow=0, $P_{ao} = P_{al} = P_{rs}$

c) $P_L = P_{al} - P_{pl} = P_{ao|flow=0} - P_{es}$



$$P_L = P_{al} - P_{pl} \qquad (1)$$

$$P_w = P_{pl} - P_{bs} \qquad (2)$$

(1) + (2)

$$P_{rs} = P_L + P_w = P_{al} - P_{bs}$$

a) $P_{bs} = 0 \rightarrow P_w = P_{pl} = P_{es}$

$$P_{rs} = P_{al}$$

P_L: transpulmonary Pr. (跨肺壓)
P_{al}: alveolar Pr.
P_{pl}: intrapleural Pr.
P_w: transthoracic Pr. (跨胸壁壓)
P_{bs}: body surface Pr.
P_{rs}: respiratory sys. Pr.
P_{ao}: airway opening Pr.
P_{es}: esophageal Pr.

b) $P_{ao} = \dot{V}R_{aw} + P_{al}$

When flow=0, $P_{ao} = P_{al} = P_{rs}$

c) $P_L = P_{al} - P_{pl} = P_{ao|flow=0} - P_{es}$

Key Points

- General concepts and terminology
- Mechanical properties
  - 1. Compliance (順應性)
  - 2. Resistance
  - 3. Pressure-volume (P-V) curve of the lungs
  - 4. Lung-chest wall coupling

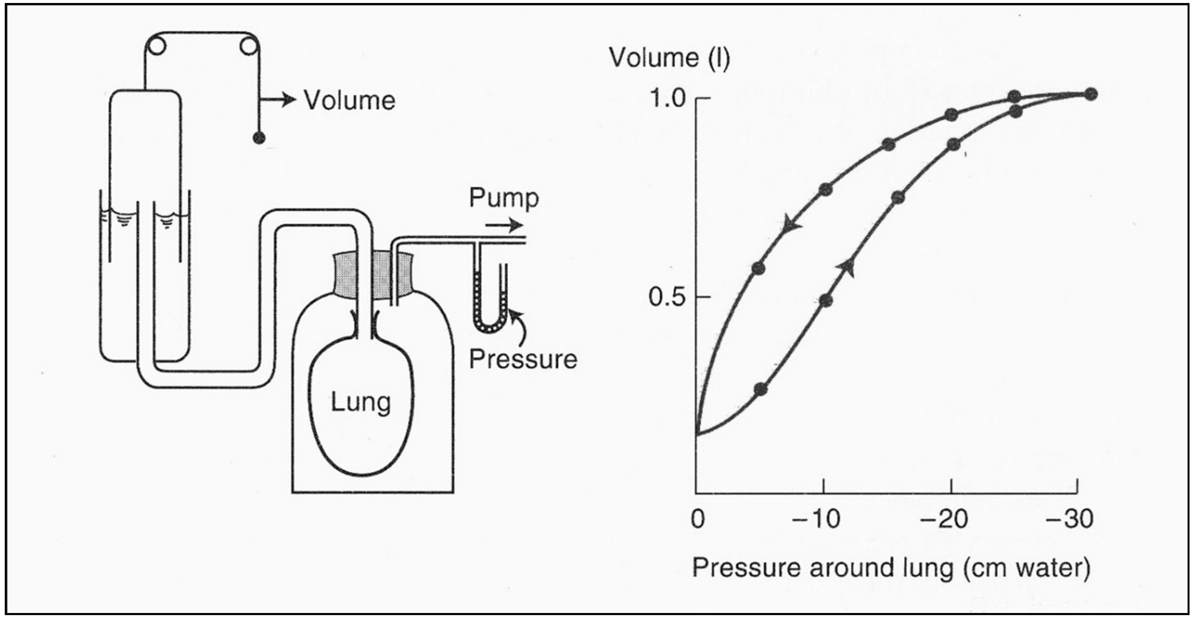
Static Mechanical Properties

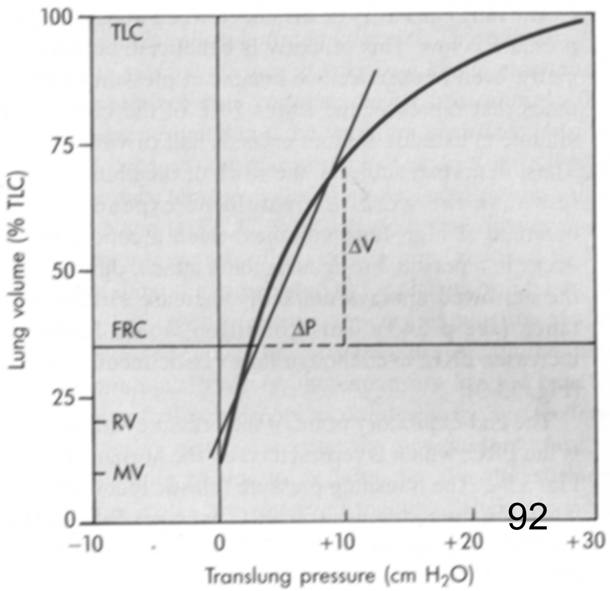
- Compliance (順應性;C): the ease with which an object can be deformed

Elastic Recoil of the Lung

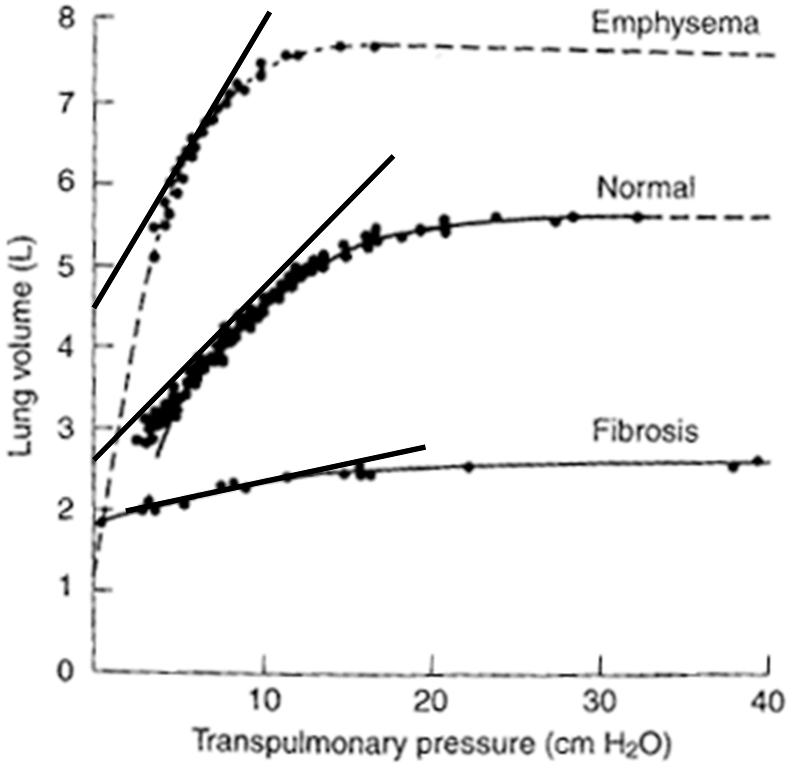
- Lung compliance: the slope of the line between any two points on the deflation limb of the pressure-volume loop

$$C_L = \frac{\Delta V_L}{\Delta P_L}$$





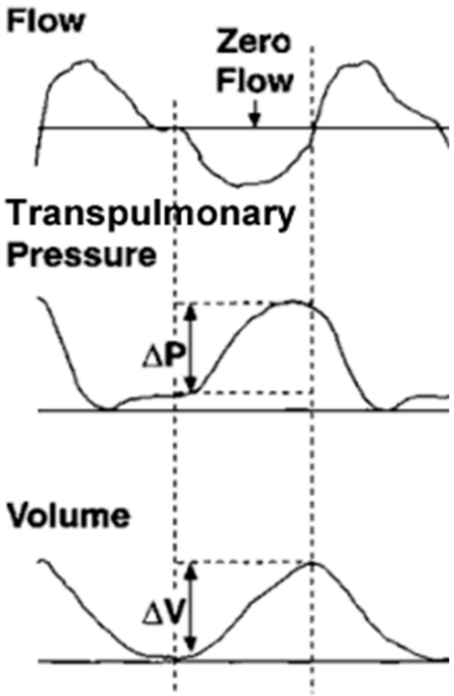
Compliance Changes in Different Diseases



In chronic obstructive pulmonary disease (COPD),
alveolar walls progressively degenerate
→ C_L increase

In pulmonary fibrosis,
→ C_L decrease

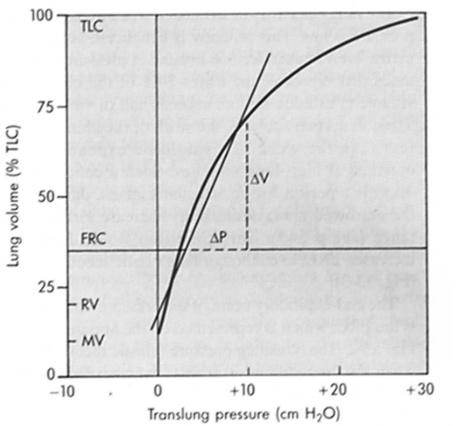
Calculation of Compliance of Lung



Dynamic compliance of lung:
measured at the end-inspiratory and end-expiratory points of no flow

$$\text{dyn } C_L = \frac{\Delta V_L}{\Delta P_L}$$

- P_{total} = resistive Pr + elastic Pr = $\dot{V}R + \dfrac{\Delta V}{C}$



Static compliance of lung
measured at the deflation limb

The dynamic compliance of lung is smaller than the static compliance

Key Points

- General concepts and terminology
- Mechanical properties
  - 1. Compliance
  - 2. Resistance (阻力)
  - 3. Pressure-volume (P-V) curve of the lungs
  - 4. Lung-chest wall coupling

Resistance

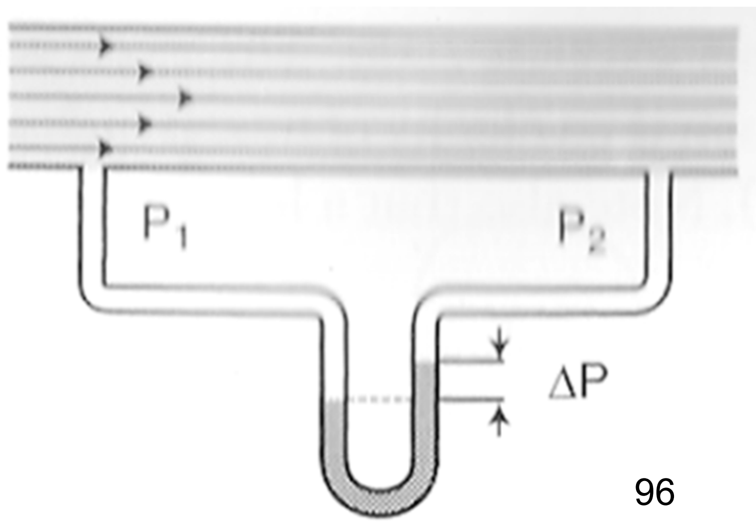
- Resp. Resistance:
  - Airway resistance (70~80%)
  - Tissue resistance (20%): movement of lung tissue, chest wall and abdominal contents

- Airway resistance (氣管阻力): the pressure difference between the alveoli and the mouth per unit of airflow

$$P_{ao} = \dot{V}R_{aw} + P_{al}$$

$$\rightarrow R_{aw} = \frac{P_{ao} - Pal}{\dot{V}}$$

P_{ao}: airway opening Pr.



The Airway Resistance

- P_{rs} = resistive Pr + elastic Pr = = $\dot{V}R_{aw} + \frac{\Delta V}{C}$

$$\rightarrow R_{aw} = \frac{P_{rs} - \frac{\Delta V}{C}}{\dot{V}} \qquad (1)$$

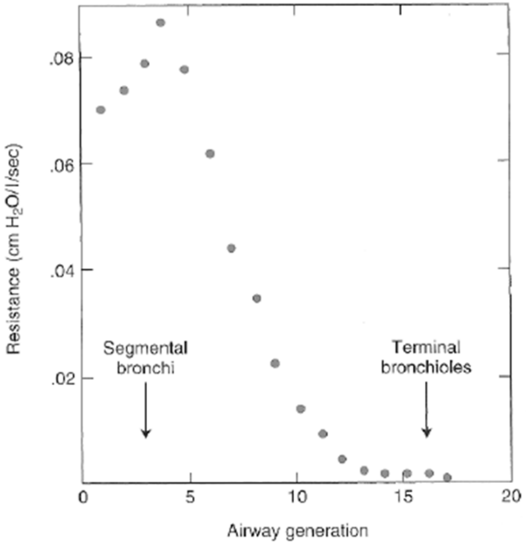
- In laminar flow, flow is proportional to ΔP by Poiseuille's law

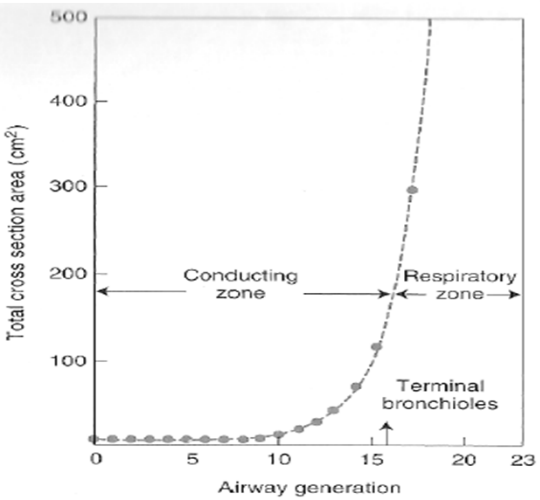
$$Q = \frac{\pi r^4 (P_1 - P_2)}{8\eta l} \qquad (2)$$

$$\rightarrow R_{aw} = \frac{(Prs - \frac{\Delta V}{C}) \times 8\eta l}{\pi r^4 (P_1 - P_2)}$$

- Resistance is inversely proportional to the fourth power of the airway radius

The Airway Resistance





- Poiseuille's law: $R \propto \frac{1}{r^4}$
- Individual resistance:

  small airway >> large airway
- Total resistance:

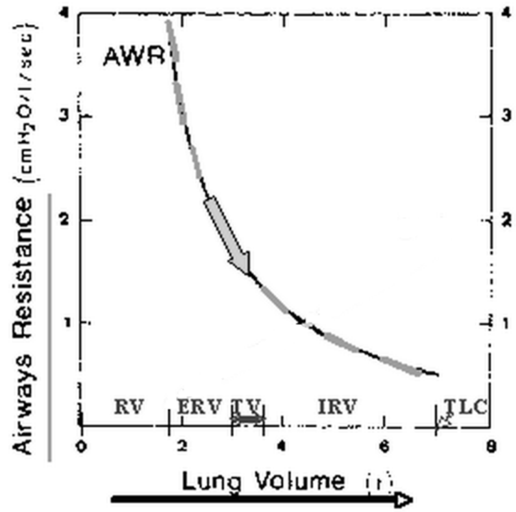
  small airway < large airway

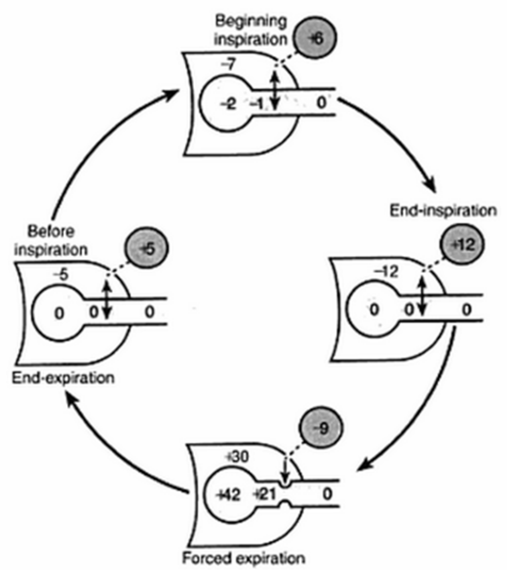
✓ the effective cross-sectional area of many bronchioles in parallel increases

The Airway Resistance

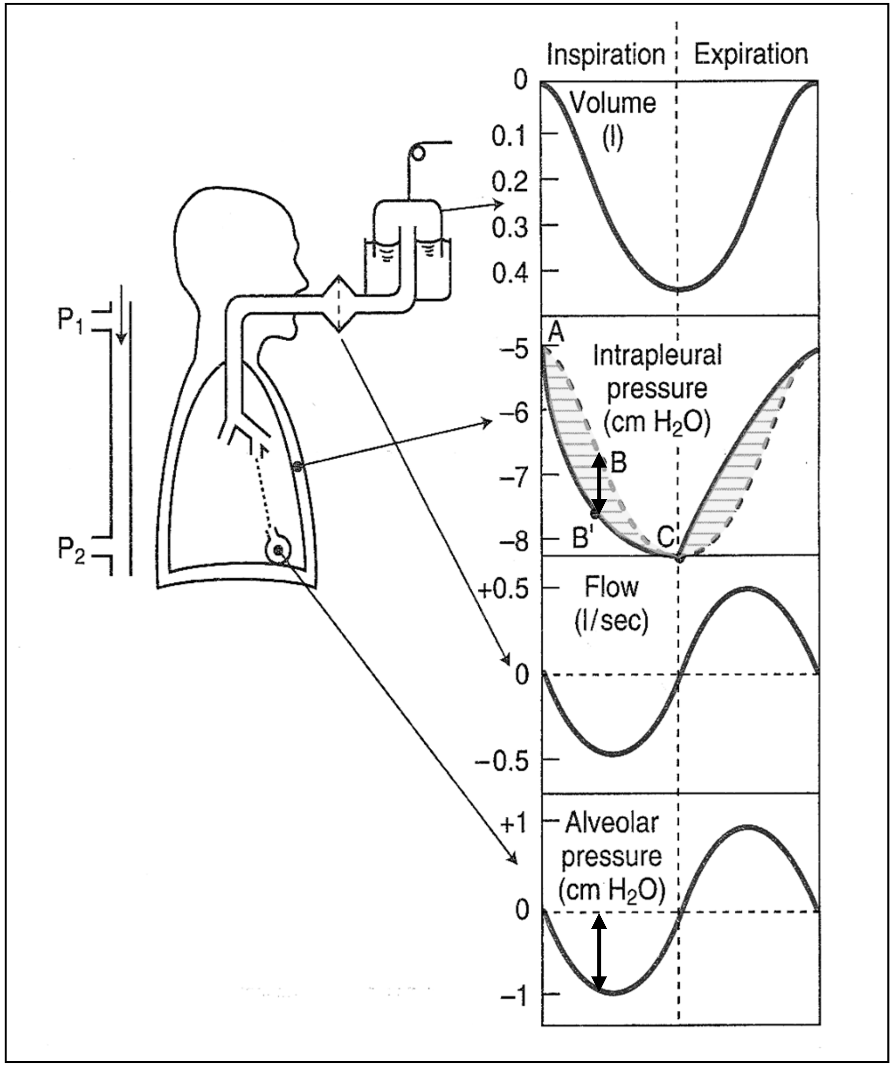
- Airway resistance ↓ as lung volume ↑
  → the airways distend as the lungs inflate
- The airways are narrower during expiration
  → $R_{exp} > R_{insp}$

- Factors affecting the radius of bronchioles
  - Airway constriction: histamine; parasymp. n.
  - Airway dilation: epinephrine; symp. n.



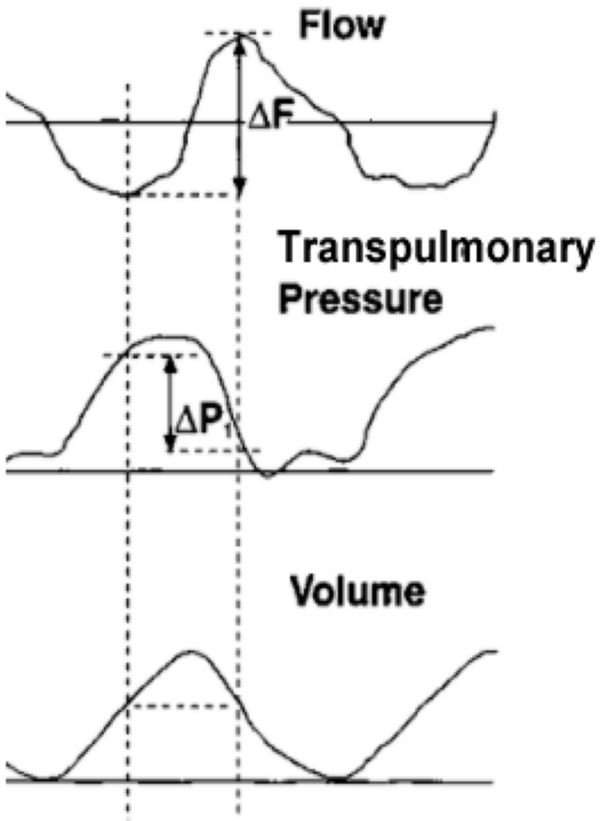


The Airway Resistance



- If no resistance exists, intrapleural pressure should be along the broken line
- The vertical distance between lines ABC and AB'C reflects the alveolar pressure
- Airway resistance contributes the hatched portion of intrapleural pressure

Calculation of Dynamic Resistance



Dynamic airway resistance of respiratory system:
measured at iso-volume of lung

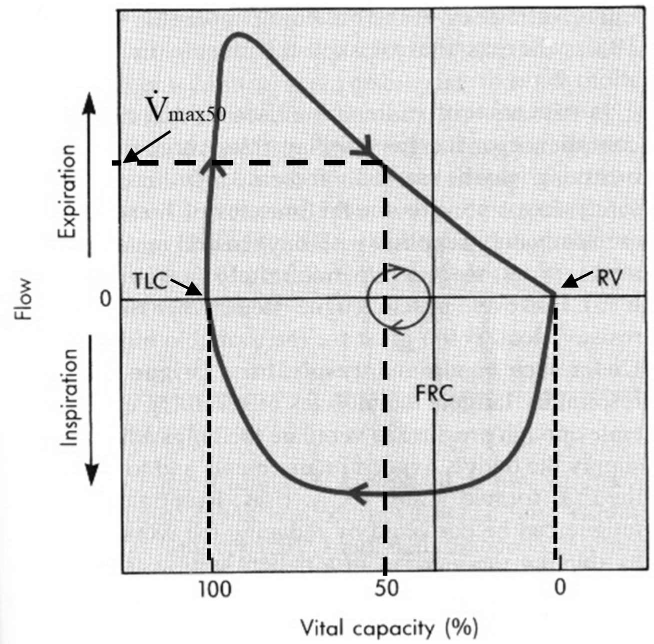
P_{total} = resistive P + elastic P

$$= \dot{V}R_{aw} + \frac{\Delta V}{C}$$

$\Delta V = 0 \rightarrow P_{total}$ = resistive P = $\dot{V}R_{aw}$

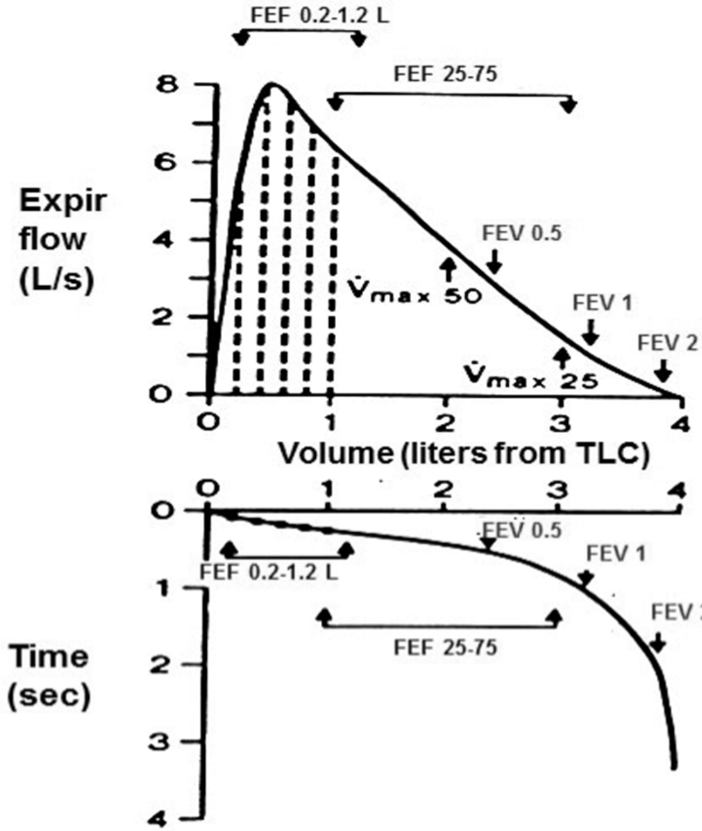
$\rightarrow R_{aw} = \frac{P}{\dot{V}} = \frac{\Delta P}{\Delta F}$

Evaluation of Airway Resistance



Flow-Volume Curve

$\dot{V}_{max50}$: $\dot{V}_{max}$ at 50% of VC

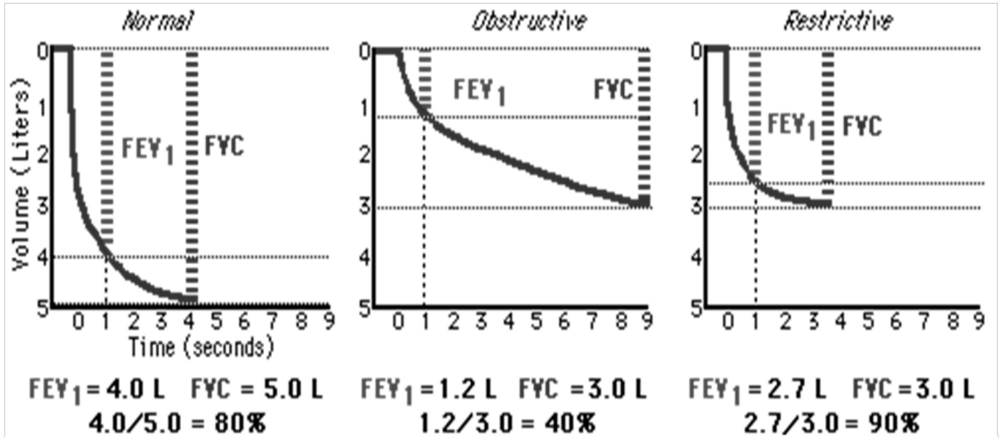


FEF: forced expiratory flow

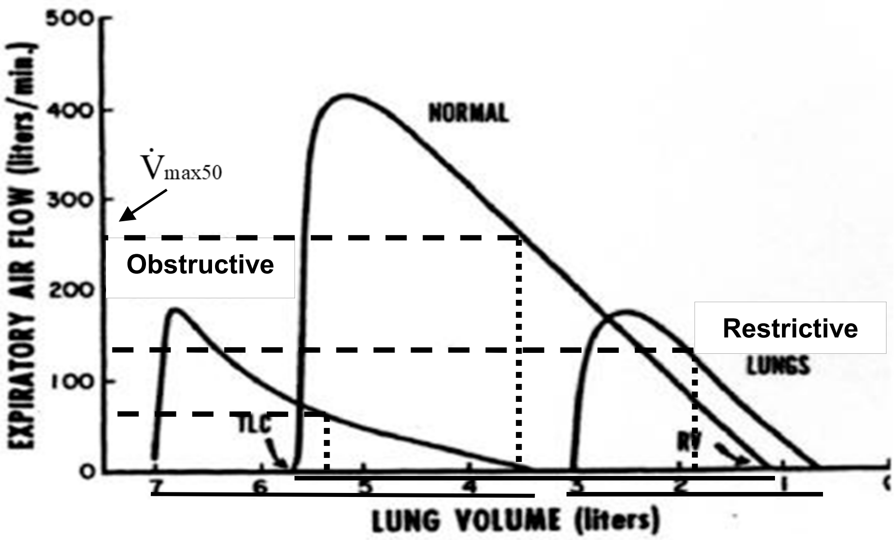
FEV_1: forced expiratory vol. in one second

Evaluation of Abnormality in Lung Vol.

FEV_1



$\dot{V}_{max50}$



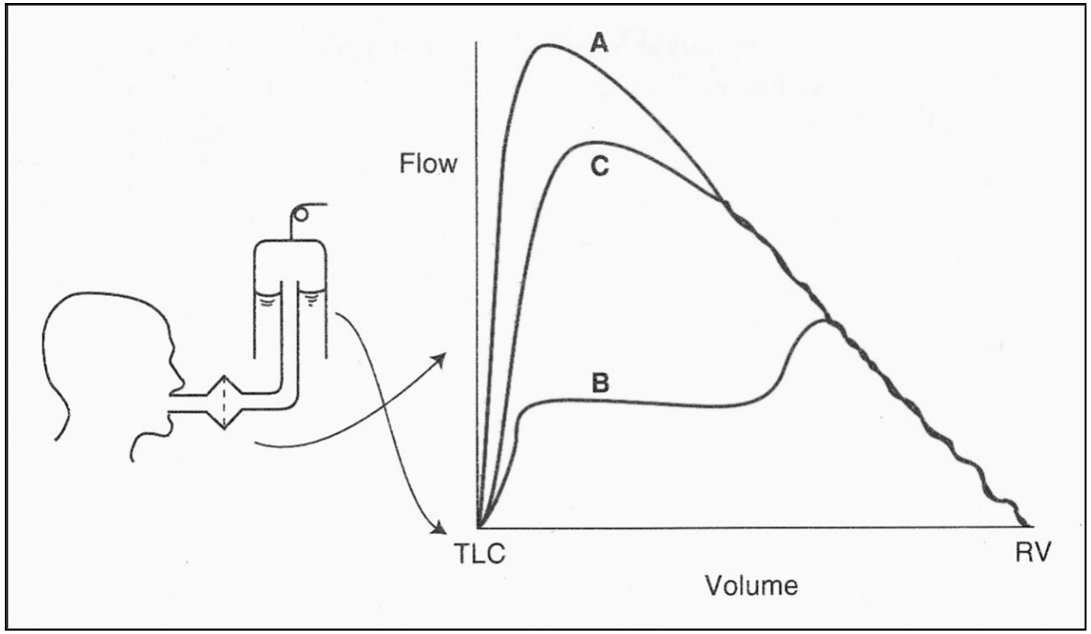
Flow-volume Curves

A: A maximal inspiration was followed by a forced expiration

B: Expiration was initially slow and then forced

C: Expiratory effort was submaximal

→ The descending portions of the curves are almost superimposed



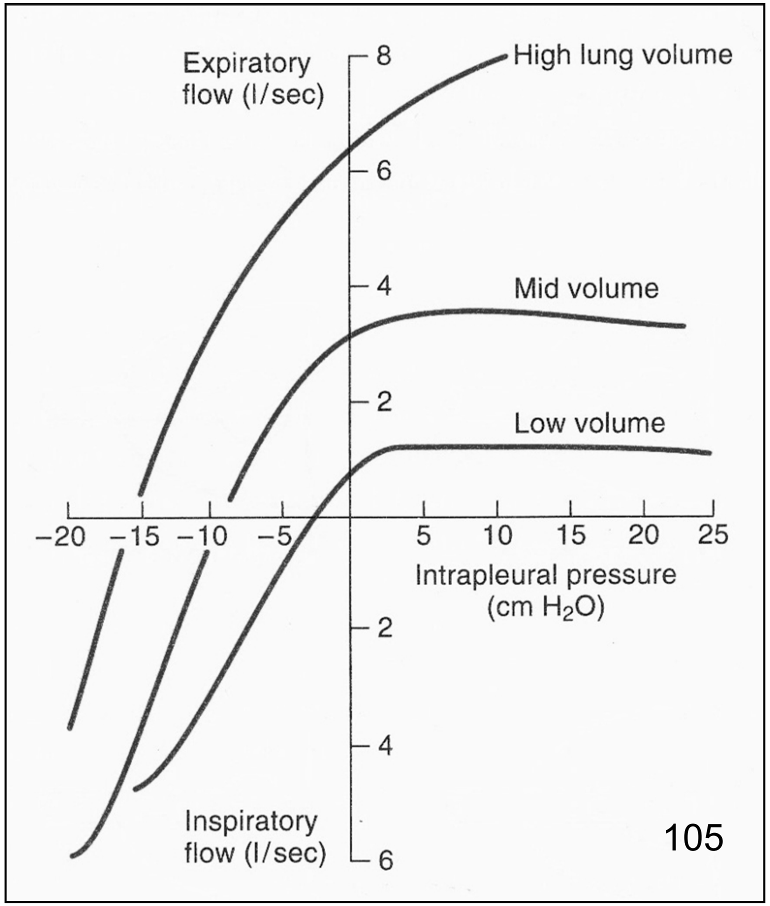
Isovolume Pressure-flow Curves

- The subject takes a series of max. insp. and then exhales fully with varying degrees of effort, the flow rates and intrapleural pressures are plotted at the same lung volume for each exp. and ins.

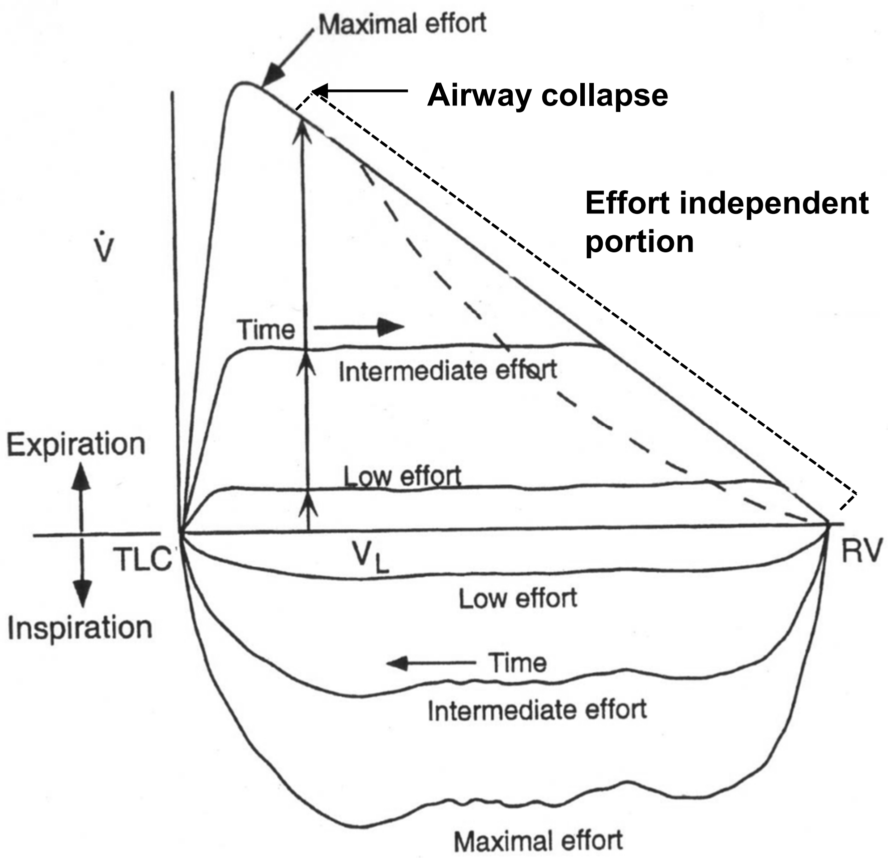
- At high lung vol.: Exp. flow rate continues to increase with effort

- At mid or low vol.: the flow rate reaches a plateau → flow is effort independent

- Max expiratory flow is dependent on lung volume, not effort

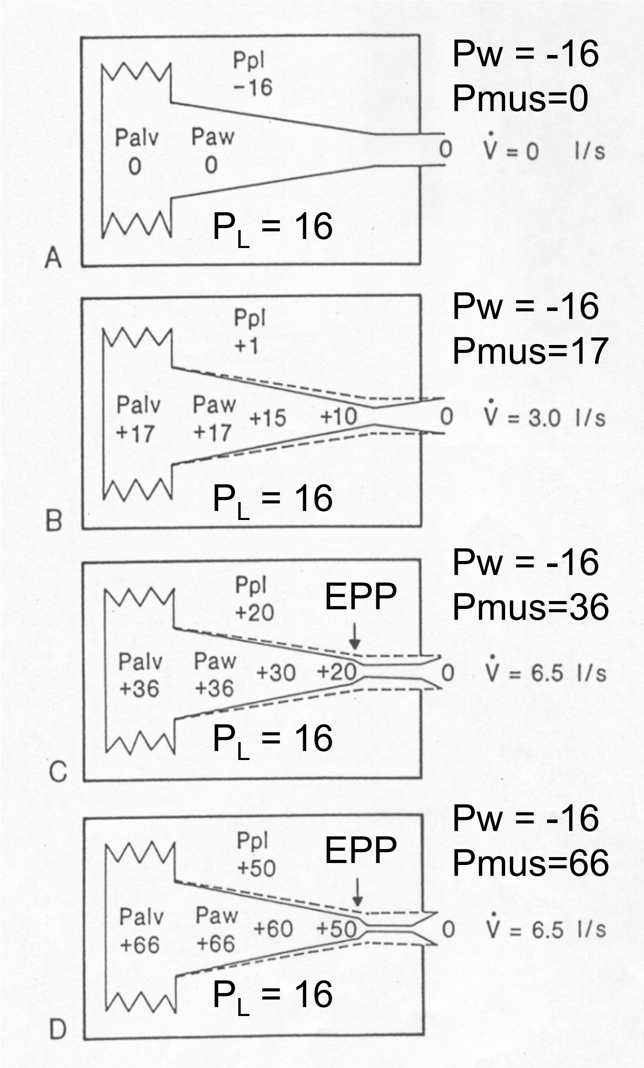


Flow-Volume Relationship



- Inspiratory flow: effort dependent
- Expiratory flow: once the linear portion is reached, it is effort independent
  - ✓ Velocity ↓ as volume ↓, but not ↓ muscular effort
- Dynamic airway compression

Dynamic Airway Compression

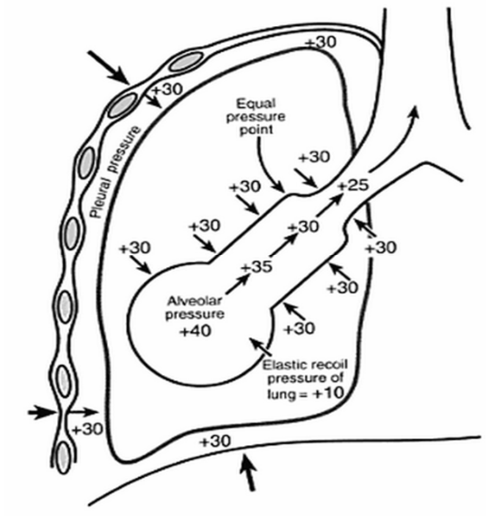


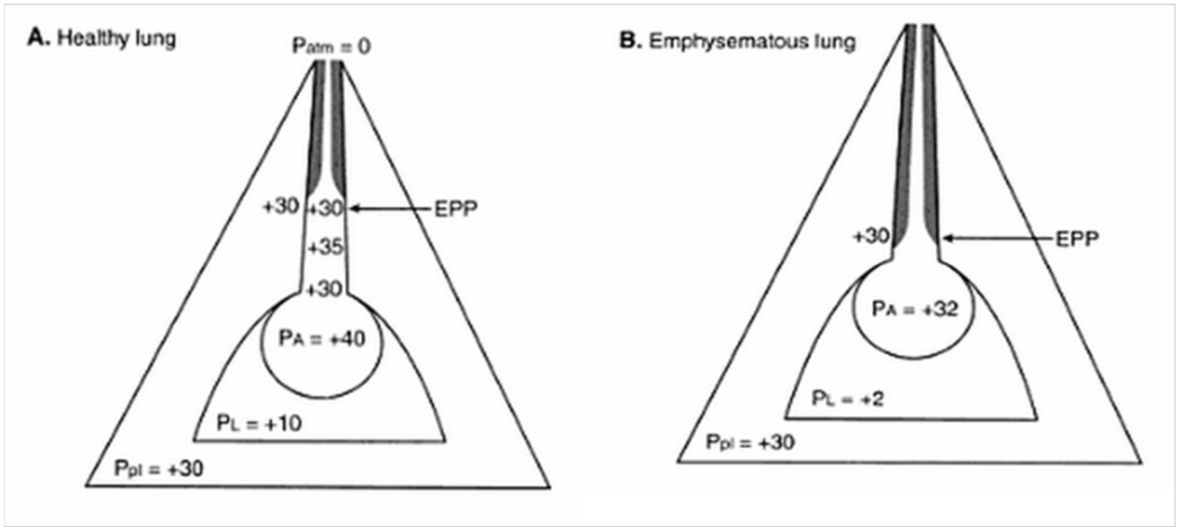
- Which lung vol. is bigger ?
  Same P_L → Same lung vol.
- How come P_{pl} is different ?
- No movement → $P_L = P_w$
  - $P_w = P_{pl} – P_{bs} – P_{mus}$
  - Diff. P_{mus} → Diff. muscle effort
- Terminology:
  - EPP: equal pressure point
  - Down stream vs up stream
- Application:
  - Pursed lip breathing in COPD patient

EPP is Influenced by Lung Elastic Recoil

- In healthy lungs, the equal pressure point (EPP) is established in larger airways ← cartilage supports airways
- In emphysematous lung,

  Reduced elastic recoil → reduced P_{al} → EPP is shifted toward alveoli and established in smaller airways → airway compressed





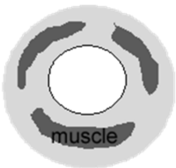
Pursed Lip Breathing (噘嘴吐氣)

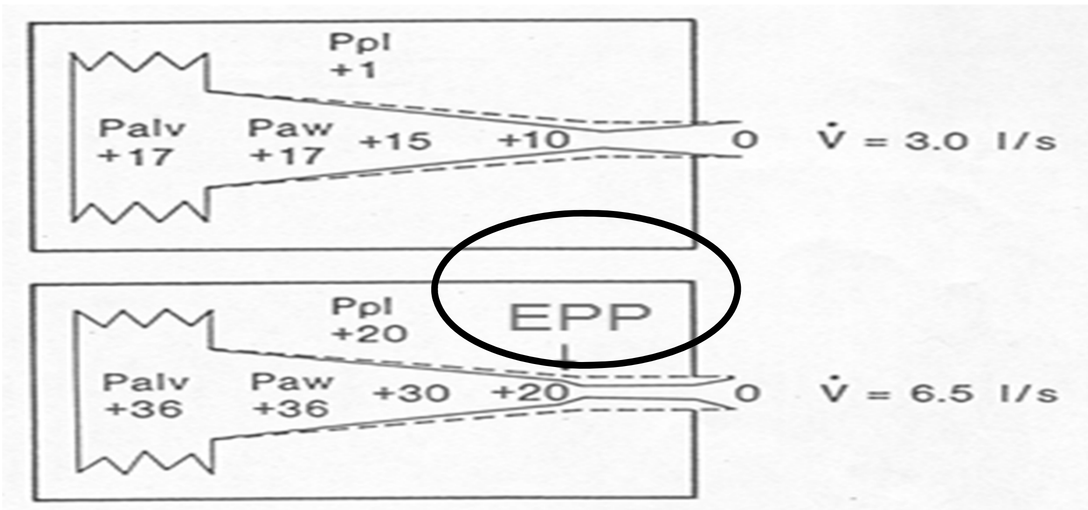
- Increase mouth pressure

→ Pressure gradient reduced

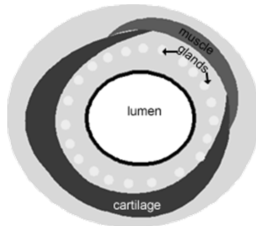
→ EPP is moved from smaller collapsible airways toward larger cartilaginous (non-collapsible) airways

Bronchiole



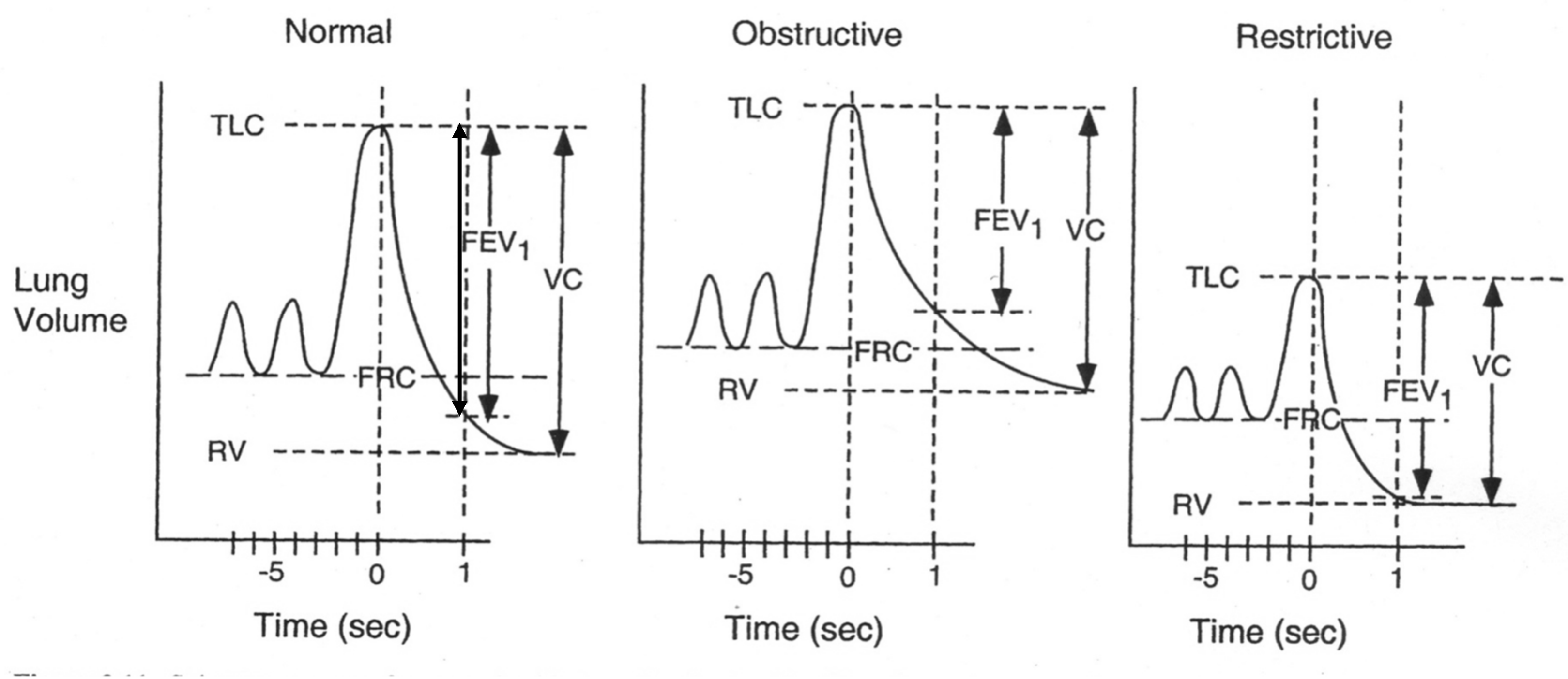


Trachea

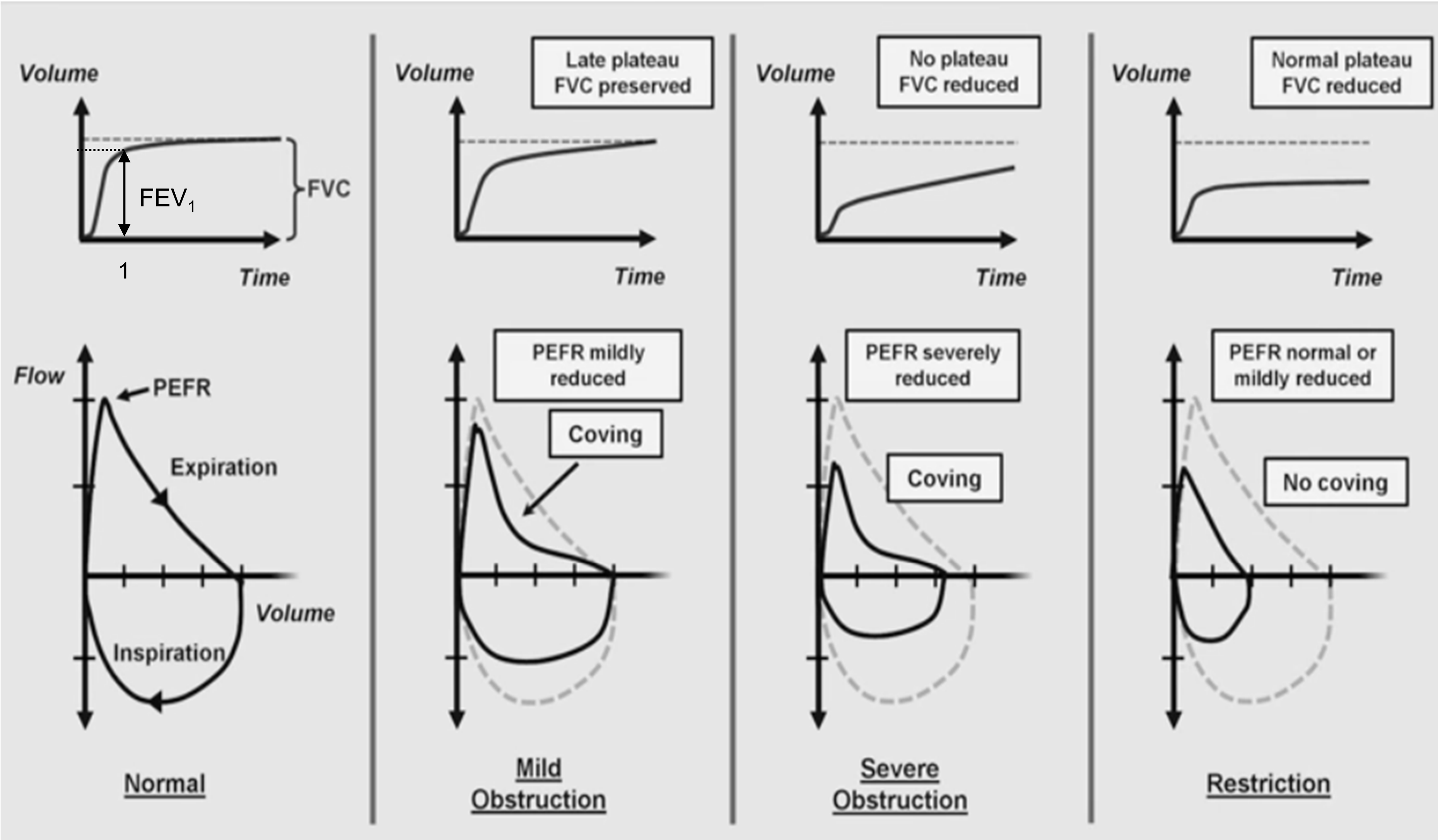


Abnormality in Lung Vol.

- Two categories of abnormality in lung volumes: obstructive (阻塞型) and restrictive (限制型)
- FEV_1: forced expiratory volume in one second



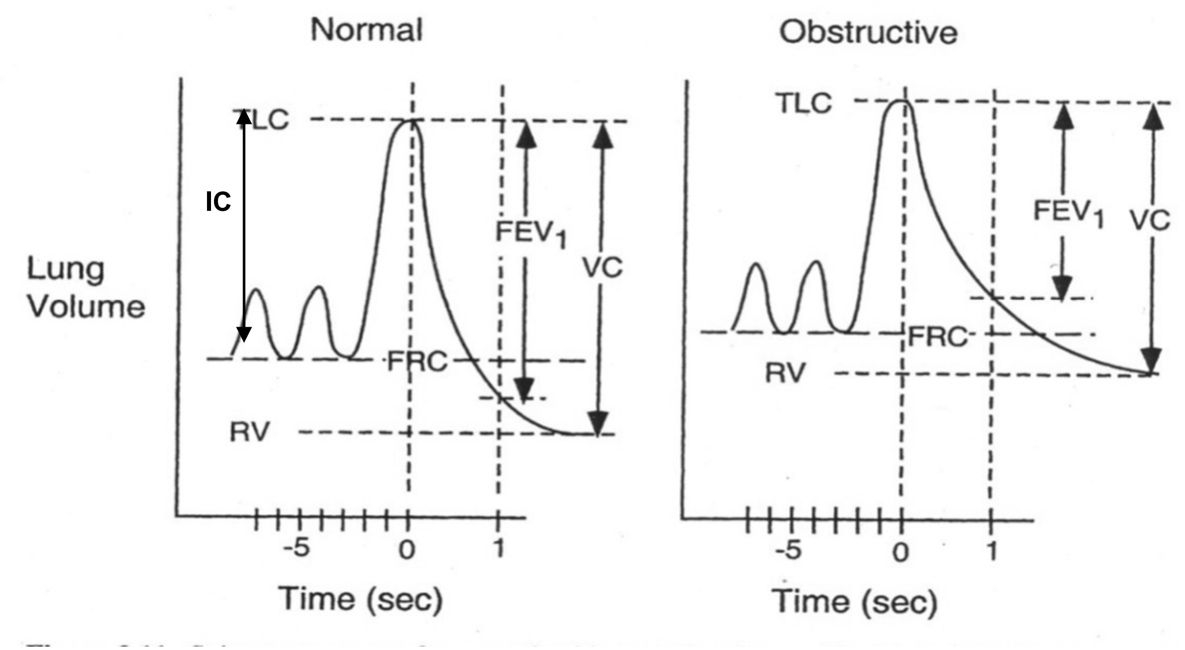
Interpretation of Flow-Vol Loop



Obstructive Lung Vol. Defect

✓ Obstructive (over-inflation): emphysema & asthma

- $\frac{FEV_1}{VC} < 70\%$
- An increase in TLC (particularly emphysema)
- A disproportionate increase in RV and FRC
- VC and IC are decreased



Chronic Obstructive Pulmonary Disease (慢性阻塞性肺病; COPD)

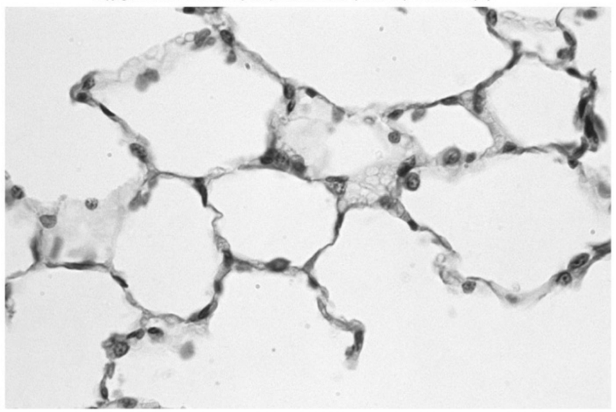
- Chronic inflammation, narrowing of the airways, and alveolar destruction
  - ✓ Includes chronic obstructive bronchiolitis and emphysema
- Accelerated decline in FEV_1
- Excessive mucus production and inflammation triggered by smoking
- Inflammation involves macrophages, neutrophils, and cytotoxic T cells

https://www.space.ntu.edu.tw/navigate/s/125A24B41FE54F45ABEF648E1472FF94QQY

Emphysema (肺氣腫)

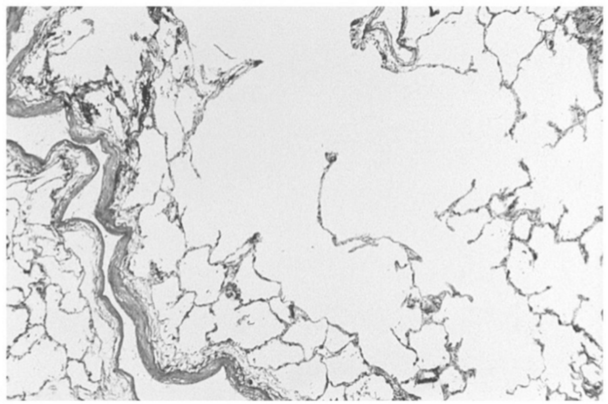
- Destruction of alveoli
- Reduces surface area for gas exchange
- With fewer alveoli to put pressure on bronchioles, they collapse during expiration
- Smoking is the most common cause
  - ✓ inflammation and destruction of alveoli by immune cells

(a)



Normal lung

(b)



Emphysema lung
(fewer and larger alveoli)

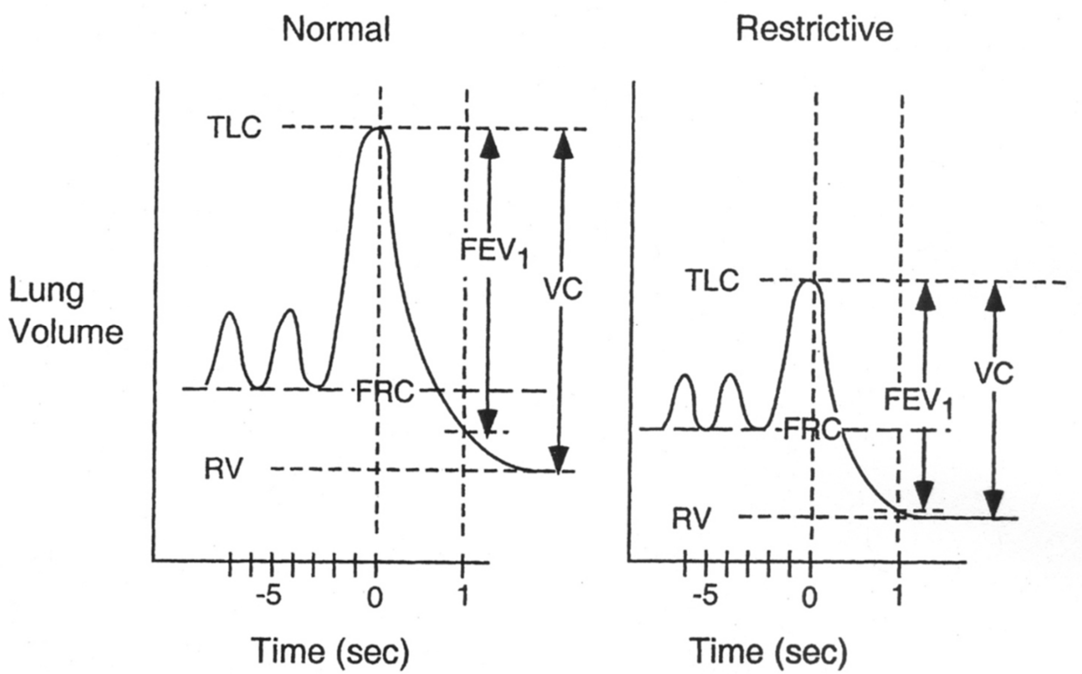
Asthma (氣喘)

- Often called airway hyper-responsiveness
- Symptoms: dyspnea (shortness of breath) and wheezing
- Causes
  - ✓ Allergic asthma: triggered by allergens stimulating T lymphocytes to secrete cytokines and recruit mast cells, which contribute to inflammation
  - ✓ Can also be triggered by cold or dry air
- Reversible with bronchodilator
  - ✓ Albuterol (adrenergic receptor agonist)

反吸煙宣傳：
吸煙豬肺示範

Restrictive Lung Vol. Defect

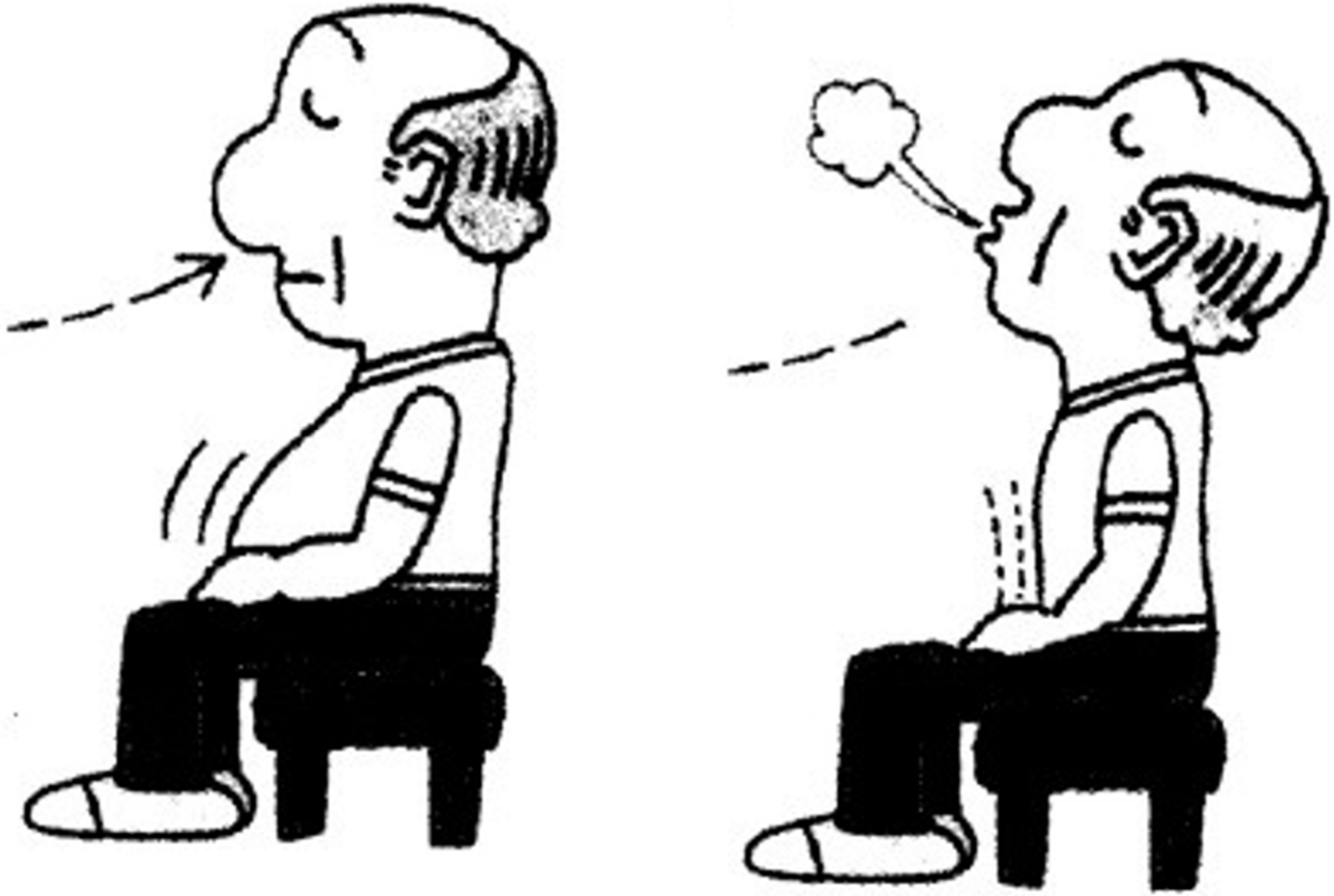
- Interstitial lung disease, respiratory m. weakness, thoracic cage deformities, such as kyphoscoliosis
- $\frac{FEV_1}{VC}$: normal or >80%
- a uniform reduction in TLC, RV, FEV_1 and VC



Examples of Restrictive Lung Dz.

- Pulmonary Fibrosis
  - ✓ fibrous tissues accumulated in the lungs when alveoli are damaged
  - ✓ May be due to inhalation of small particles
  - ✓ Example: black lung in miners
- Neuromuscular diseases, e.g., Myasthenia gravis
- Non-muscular diseases of the chest wall, e.g. kyphosis

做那些動作使呼吸效率增加?
為什麼?



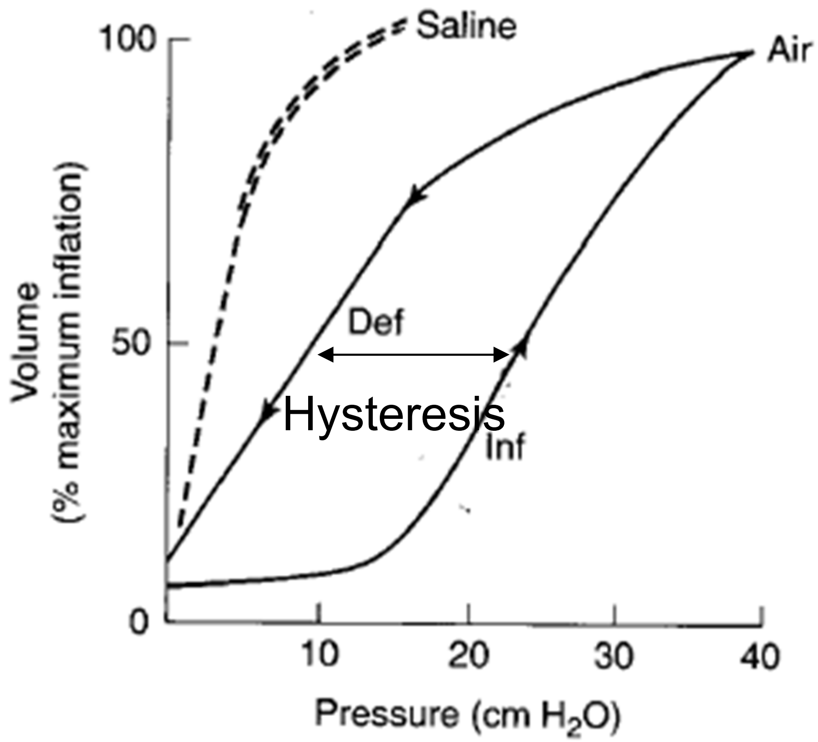
做那些動作使呼吸效率增加?為什麼?

- 腹式呼吸：
  - ✓ 橫膈為最主要吸氣肌
  - ✓使吐氣吐的完全
- 深緩呼吸：↑肺泡通氣量
- 鼻子吸氣，嘴巴噘嘴吐氣
  - ✓鼻子有過濾及溫度、濕度調節作用
  - ✓嘴巴噘嘴可↓氣管被壓縮程度，↑排氣

Key Points

- General concepts and terminology
- Mechanical properties
  - 1. Compliance
  - 2. Resistance
  - 3. Pressure-volume (P-V) curve of the lungs
  - 4. Lung-chest wall coupling

P-V Curve of the Lungs



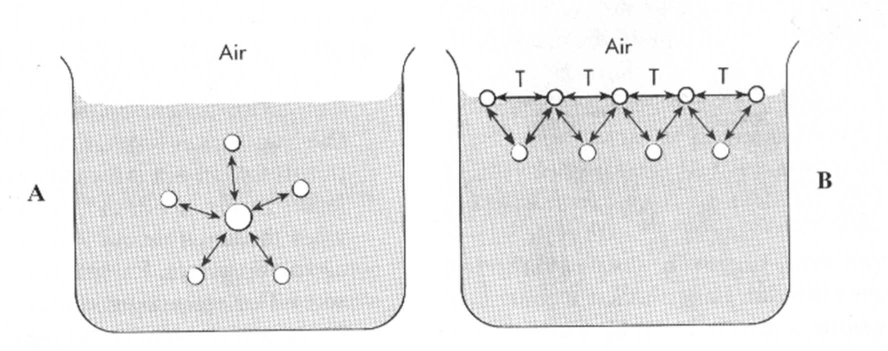
Hysteresis (遲滯; disparity between responses to inflation and deflation) is NOT due to tissue elastic recoil forces

BUT

disappearance of alveolar air-liquid interface (i.e. work against surface tension during inflation)

Surface Tension

A molecular cohesive force existing in the surface film of all liquids which tends to contract the surface to the smallest possible area



A. Force is relatively uniform on molecules in the interior
B. At the surface the molecules are pulled toward the interior and generate a compression tension (T) in the plane of the surface

Example: a soap bubble on the end of a tube

Law of LaPlace

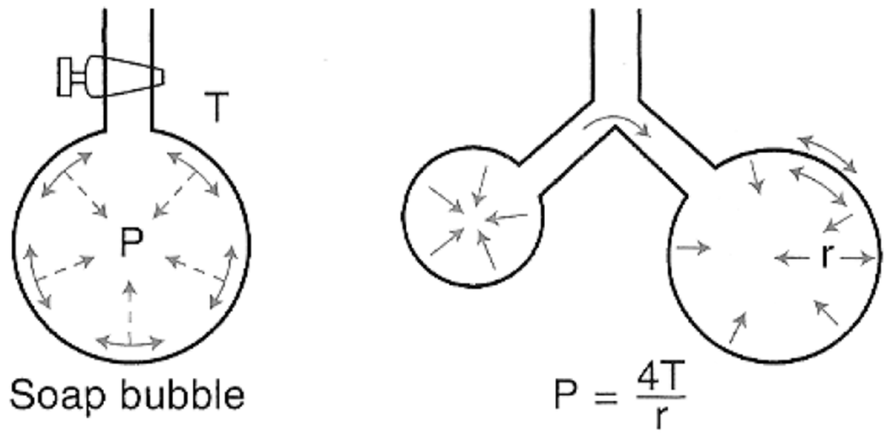
- Surface forces in a soap bubble tend to reduce the area of the surface and generate a pressure within the bubble
- LaPlace's Law:

  P = $\frac{4T}{r}$

  P: trans-mural pressure

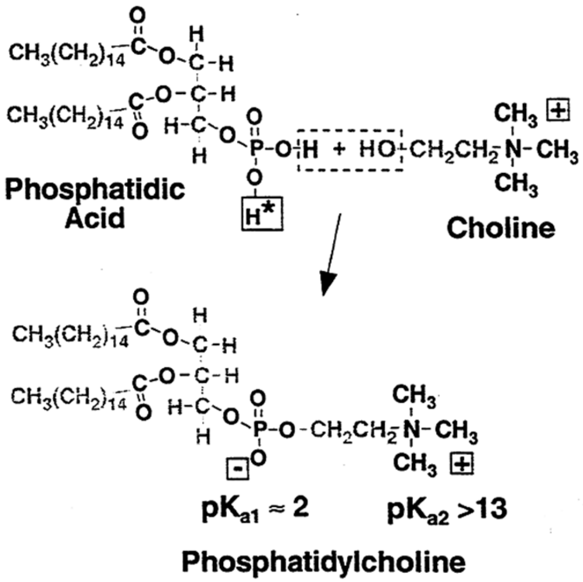
  T: surface tension

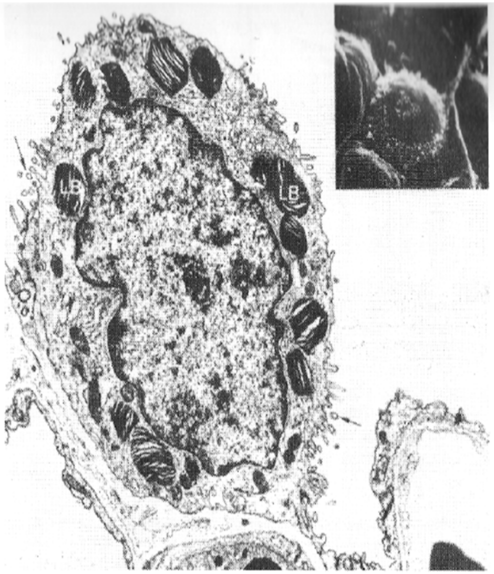
  r: radius

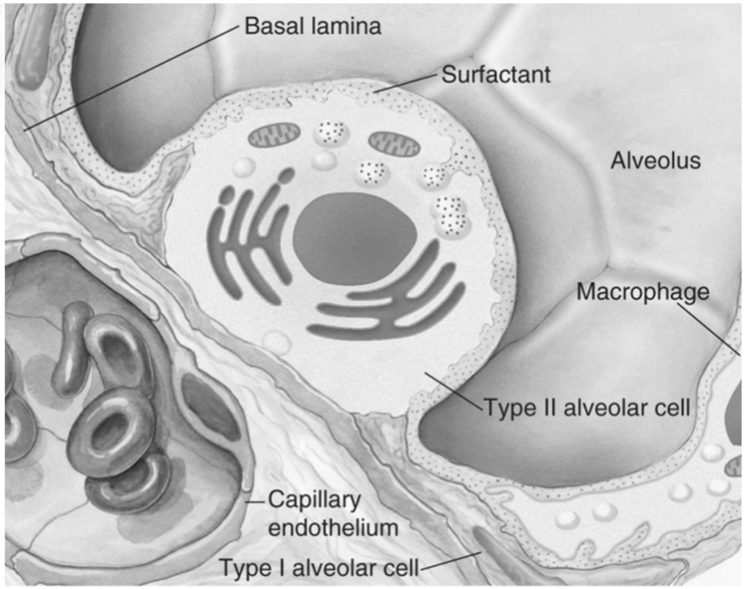


Surfactants

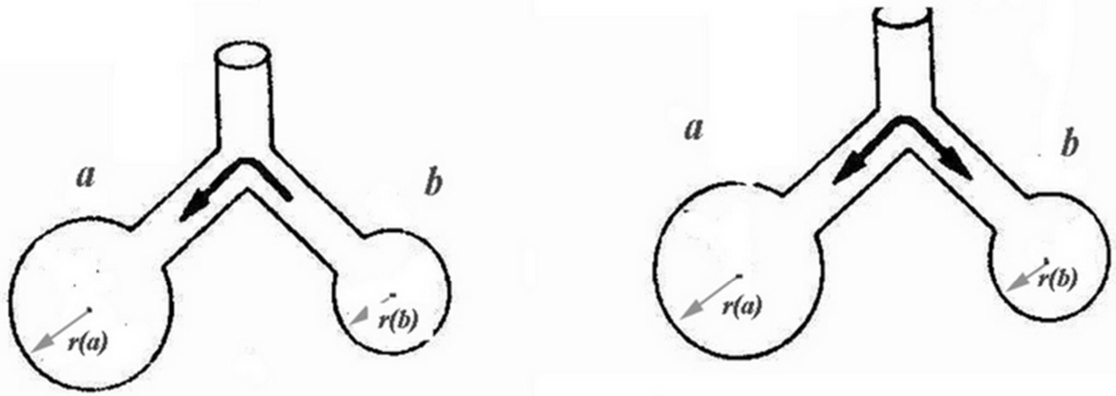
- Surfactants (界面活性劑): (e.g. detergents) lower the surface tension of water
- Lung surfactant (dipalmitoyl phosphatidylcholine, DPPC; secreted by alveolar epithelial cells type II) allows the surface tension to vary







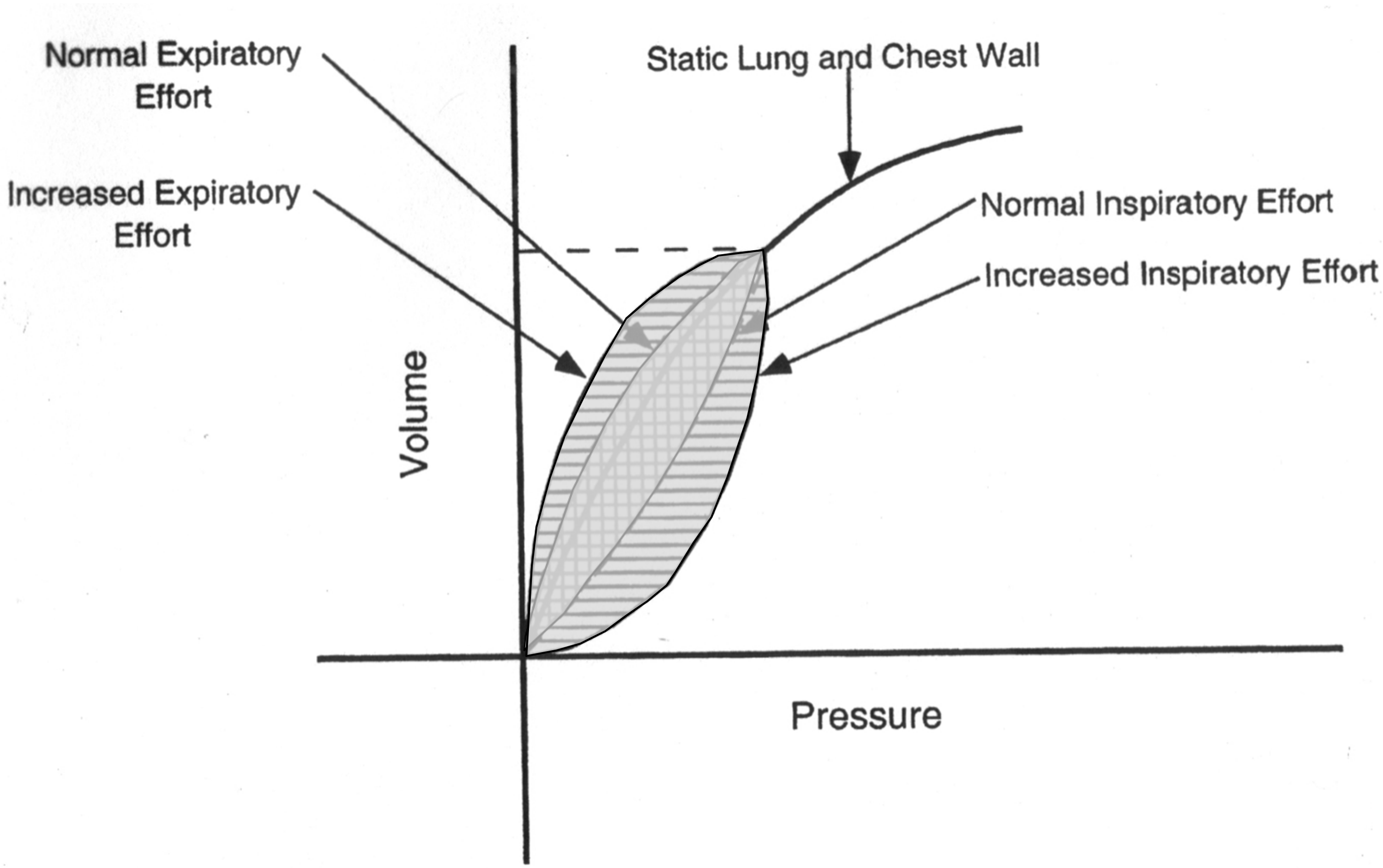
Importance of Lung Surfactant



Surfactant:	absent		present	
radius (r) :	0.1 mm	0.05 mm	0.1 mm	0.05 mm
surface tension T:	0.072 N/m	0.072 N/m	0.02 N/m	0.01 N/m
recoil pressure (2T/r):				
N/m^2	1440	2880	400	400
cm H_2O	14.4	28.8	4	4

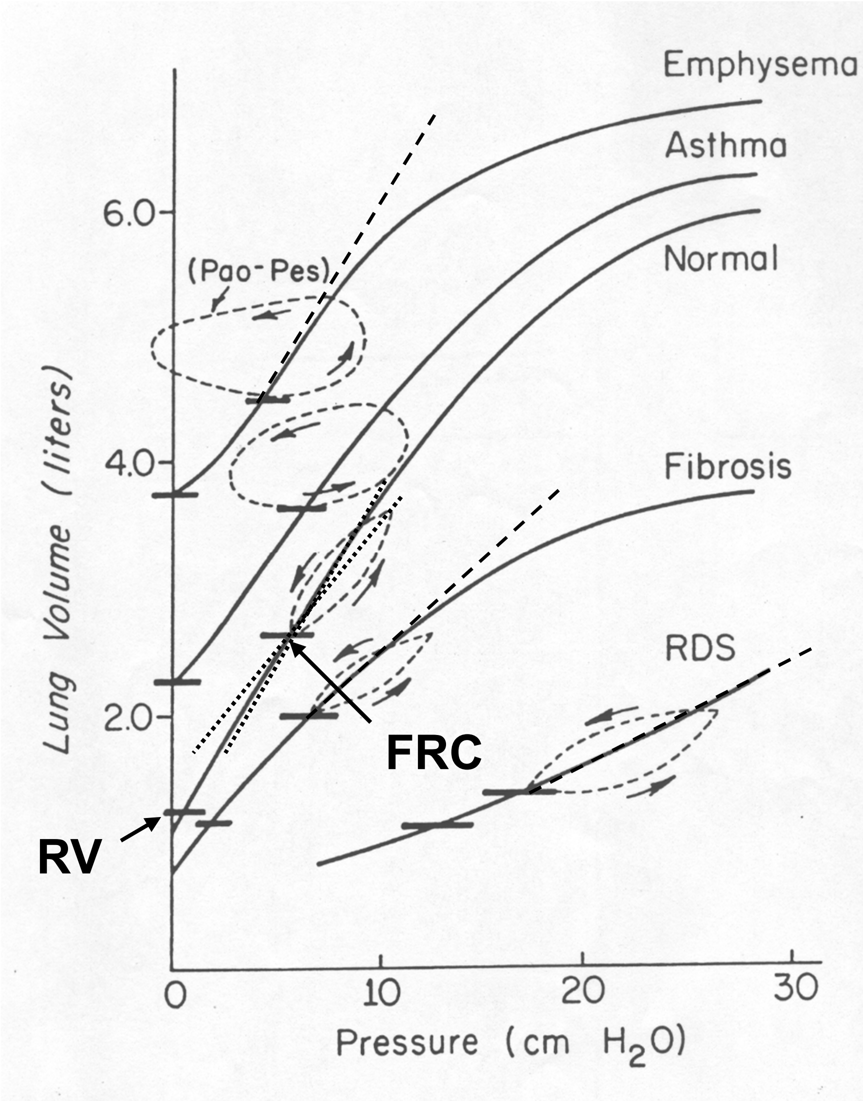
- ↓ surface tension to keep the same recoil pressure; ↑ compliance
- ↑ stability of alveoli
- ↓ vascular leakage, ↓ edema

Work of Breathing



- Area of PV loop is the work of breathing

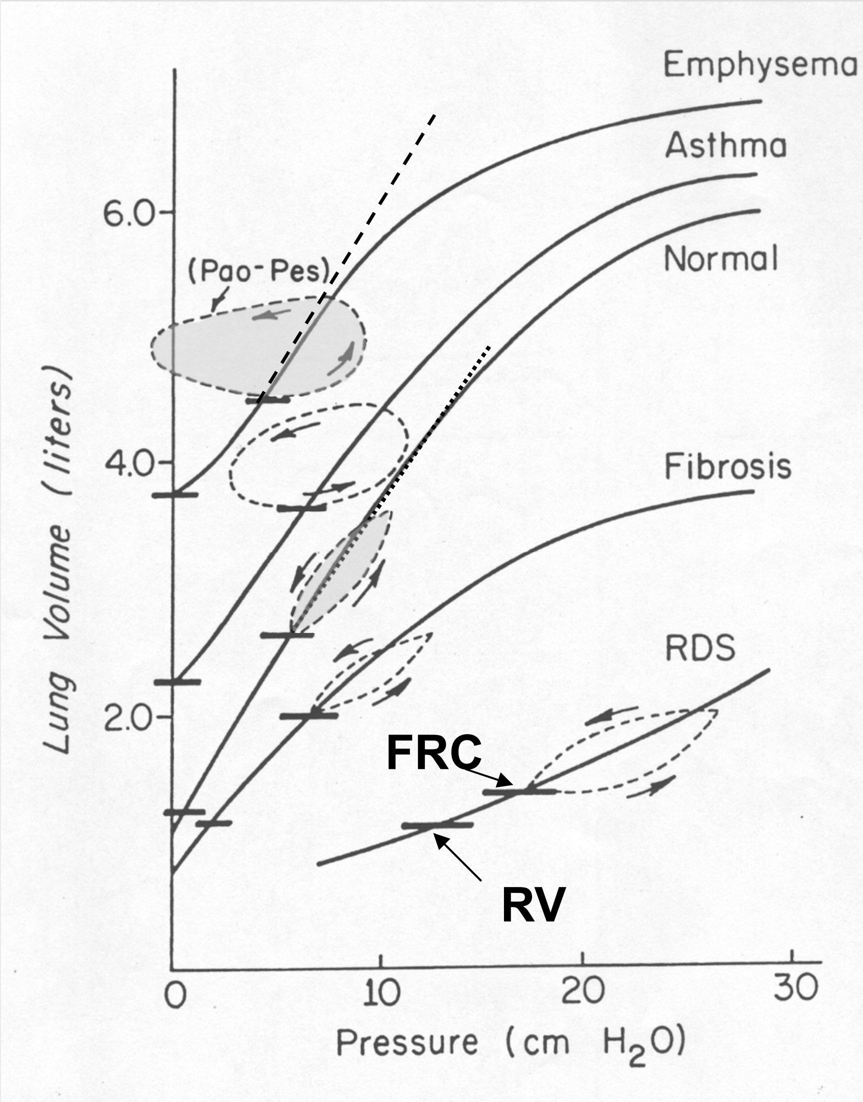
Effects of Diseases on PV Curve



- FRC, RV
- Compliance (Elastic Pr.)
  - Emphysema (肺氣腫): ↑ compliance
  - Fibrosis (肺纖維化): ↓ compliance
  - RDS (呼吸性窘迫症候群;Resp. Distress Syndrome): ↑ surface tension; ↓↓ compliance

為什麼肺氣腫的病人每次的呼吸都很吃力?

Effects of Diseases on PV Curve



- Work: area of PV loop
  P_L = resistive Pr + elastic Pr

- Emphysema:
  ✓elastic Pr ↓, but resistive Pr ↑↑
  → work ↑

Key Points

- General concepts and terminology
- Mechanical properties
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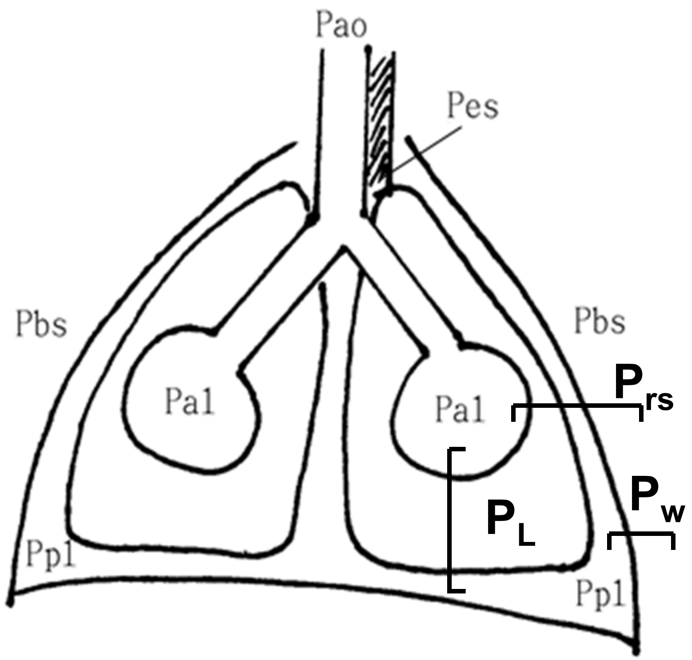


$P_L = P_{al} - P_{pl}$ (1)

$P_w = P_{pl} - P_{bs}$ (2)

(1) + (2)

$P_{rs} = P_L + P_w = P_{al} - P_{bs}$

a) $P_{bs} = 0 \rightarrow P_w = P_{pl} = P_{es}$

$P_{rs} = P_{al}$

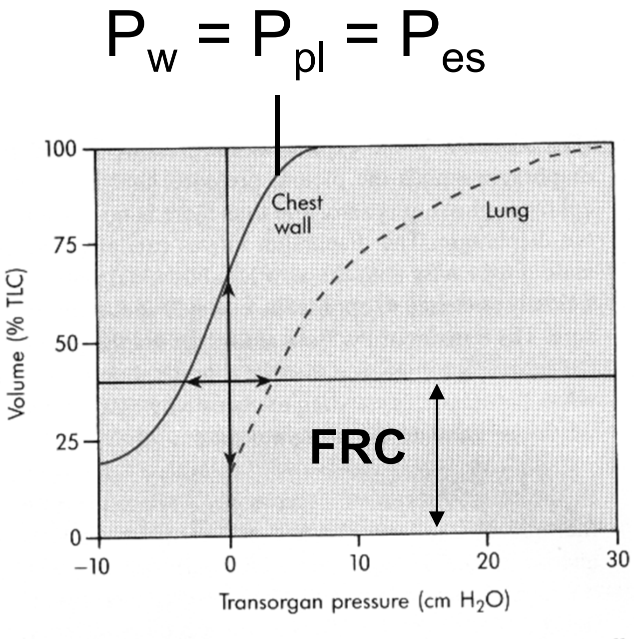
P_L: transpulmonary Pr. (跨肺壓)
P_{al}: alveolar Pr.
P_{pl}: intrapleural Pr.
P_w: trans-chest wall Pr. (跨胸壁壓)
P_{bs}: body surface Pr.
P_{rs}: respiratory sys. Pr.
P_{ao}: airway opening Pr.
P_{es}: esophageal Pr.

b) $P_{ao} = \dot{V}R_{aw} + P_{al}$

When flow=0, $P_{ao} = P_{al} = P_{rs}$

c) $P_L = P_{al} - P_{pl} = P_{ao|flow=0} - P_{es}$

Elastic Recoil of the Chest Wall



- $P_w < 0$, the chest wall is compressed

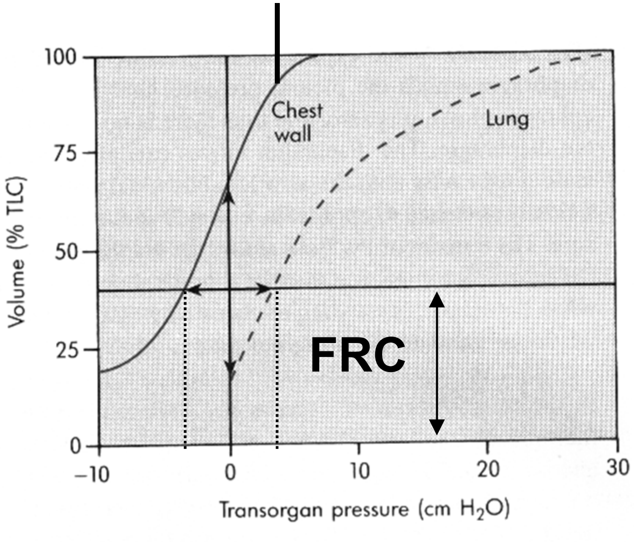
So, in pneumothorax

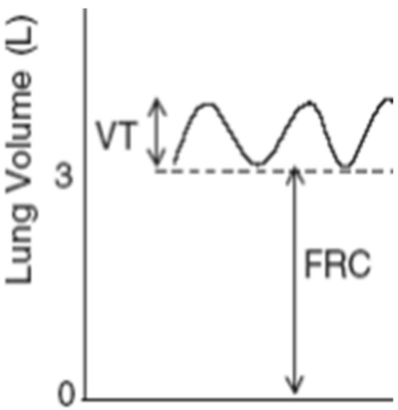
⇒ thoracic cavity increases

- The dynamic compliance of cell wall is not different from its static compliance

Elastic Recoil of the Chest Wall

$P_w = P_{pl} = P_{es}$

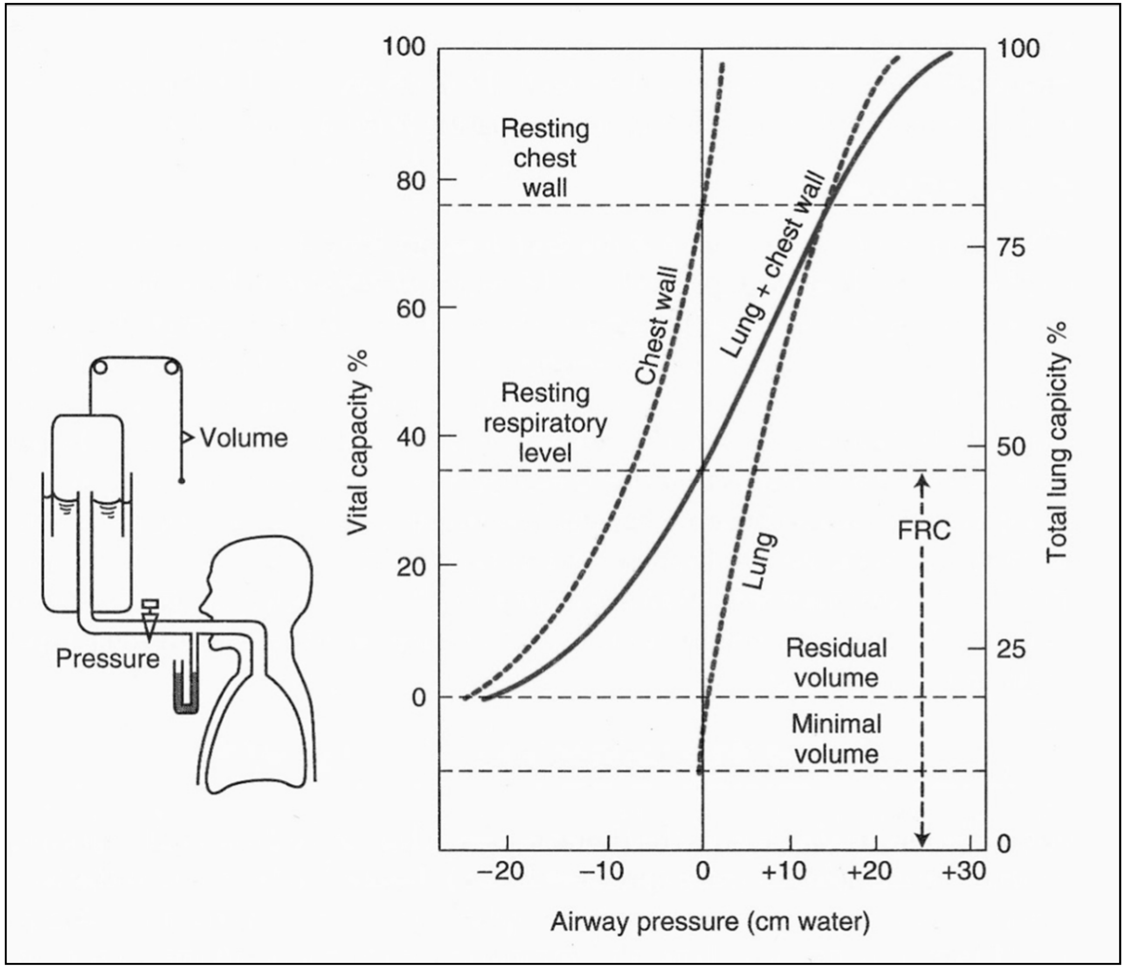




- FRC (*functional residual capacity)* is where the recoil forces of chest wall is equal but opposite to the recoil forces of the lung
- When lung vol. is below FRC, the chest wall becomes progressively stiffer (C_w decreases)
- When lung vol. is above FRC, →P_w changes from negative to positive

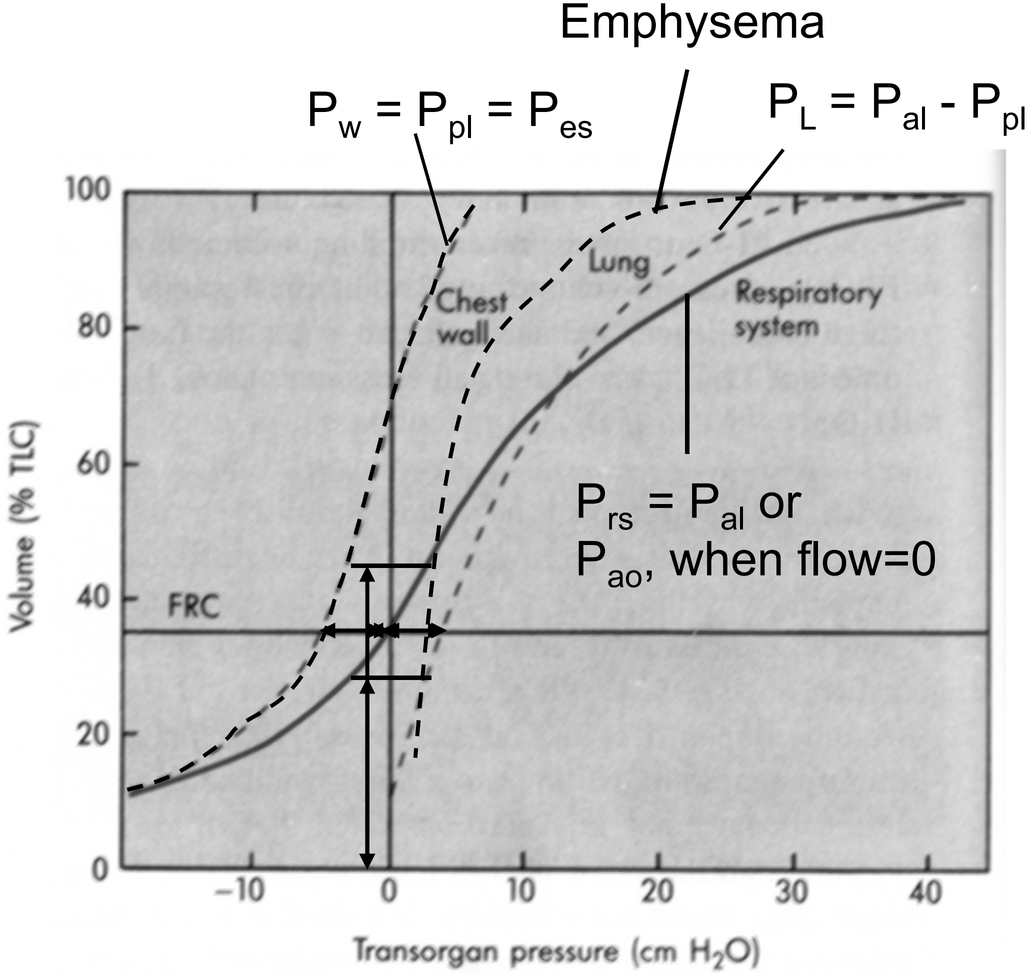
→ C_w increases and constant until the lung vol. is near TLC

Lung-Chest Wall Coupling in Static Status at Different Lung Volume



- $P_w = P_{pl} = P_{es}$
- $P_{rs} = P_{al}$ or P_{ao}, when flow=0
- $P_L = P_{al} - P_{pl}$

Lung-chest Wall Coupling to Determine FRC



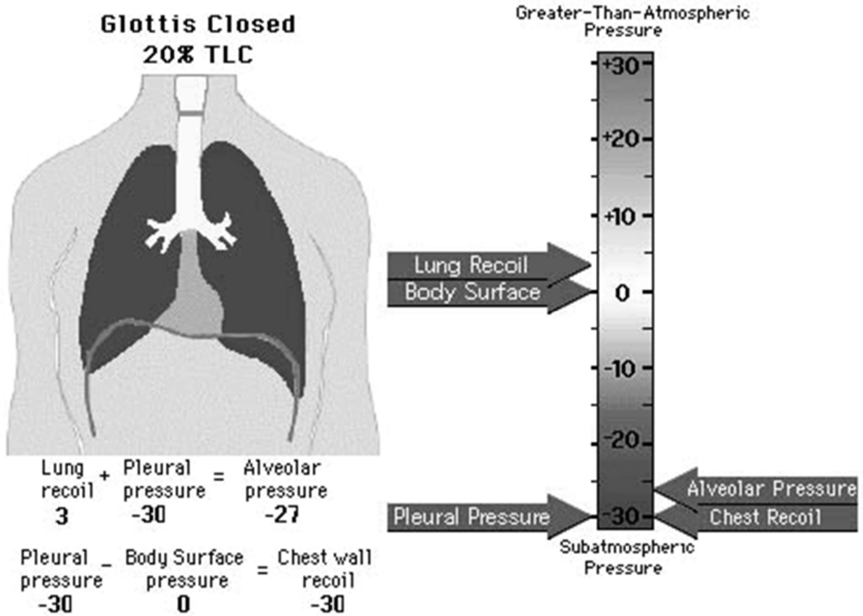
At FRC, $P_{rs} = 0 = P_L + P_W$

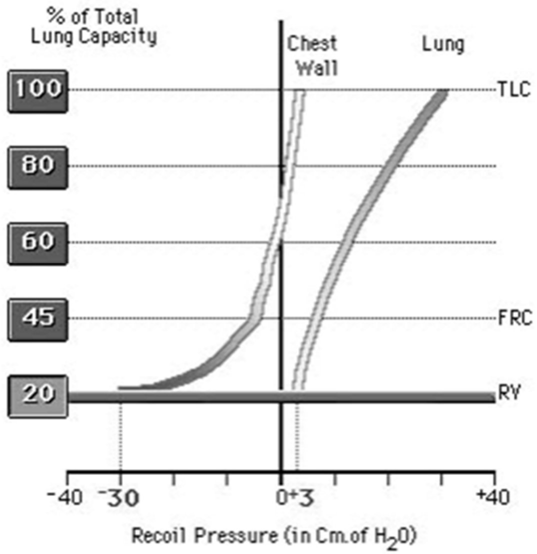
If P_w shifts to right, e.g. kyphoscoliosis (restrictive lung disease)
→ FRC decrease

In emphysema (obstructive lung disease), C_L increases
→ P_L shifts to left
→ FRC increase

Static Elastic Properties of the Lung and Chest Wall

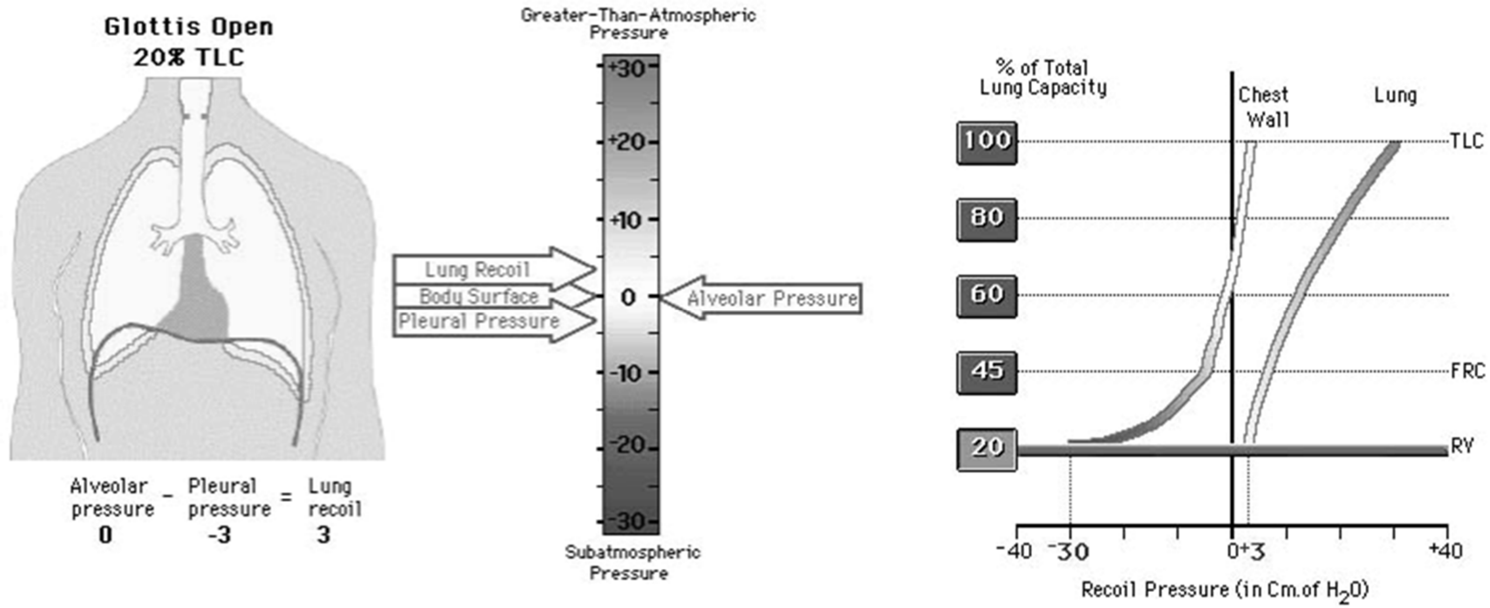
When glottis is close at the 20% of TLC (so that volume remains constant), and respiratory muscles are relax (so that the chest wall can act in an elastic fashion), what will the Ppl and Pal be?



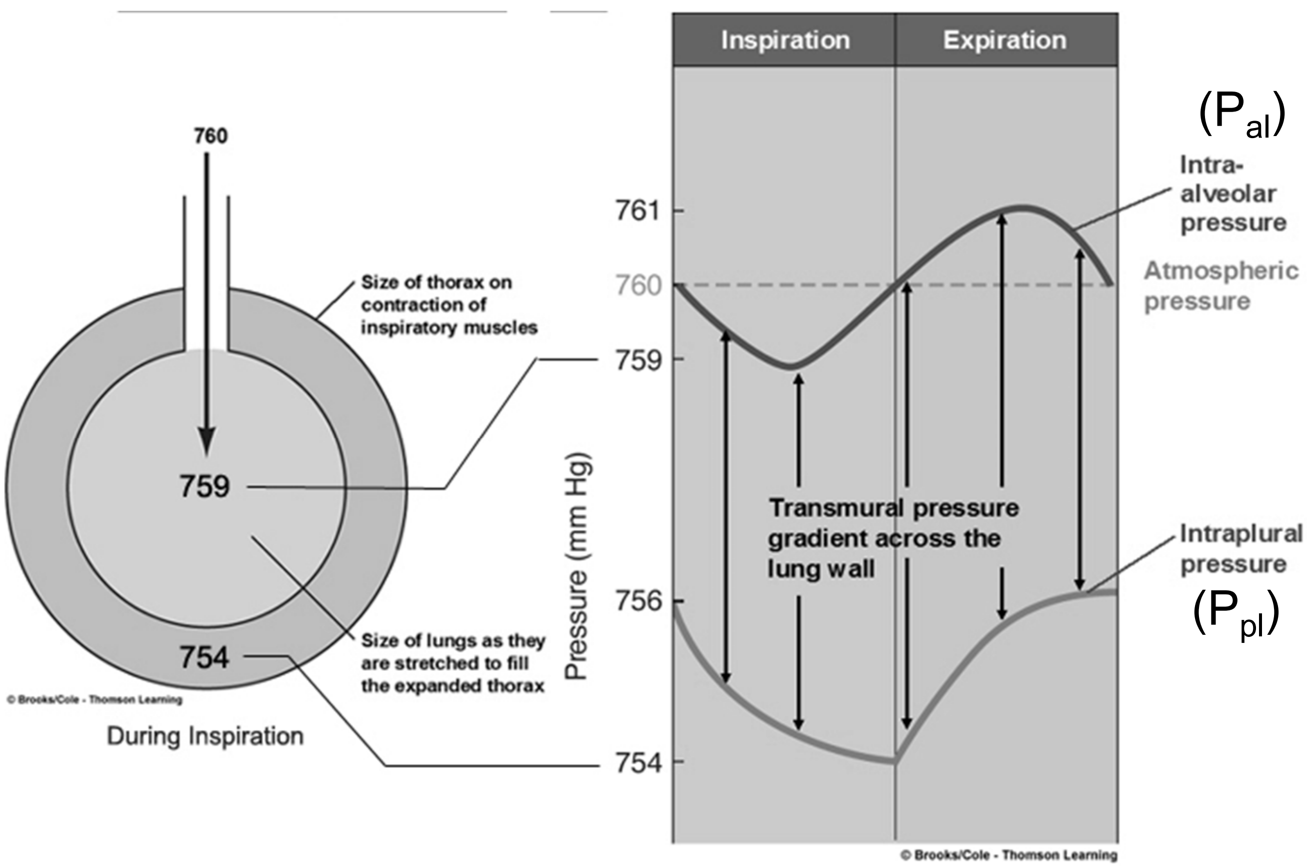


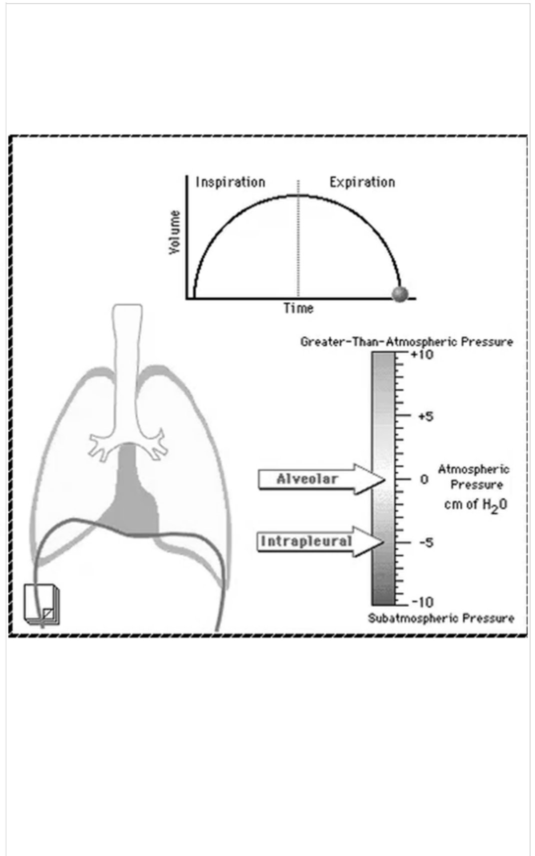
Static Elastic Properties of the Lung and Chest Wall

When glottis is open, If someone contracts the respiratory muscles to hold lung volume at 20% of TLC, what will the Ppl and Pal be?

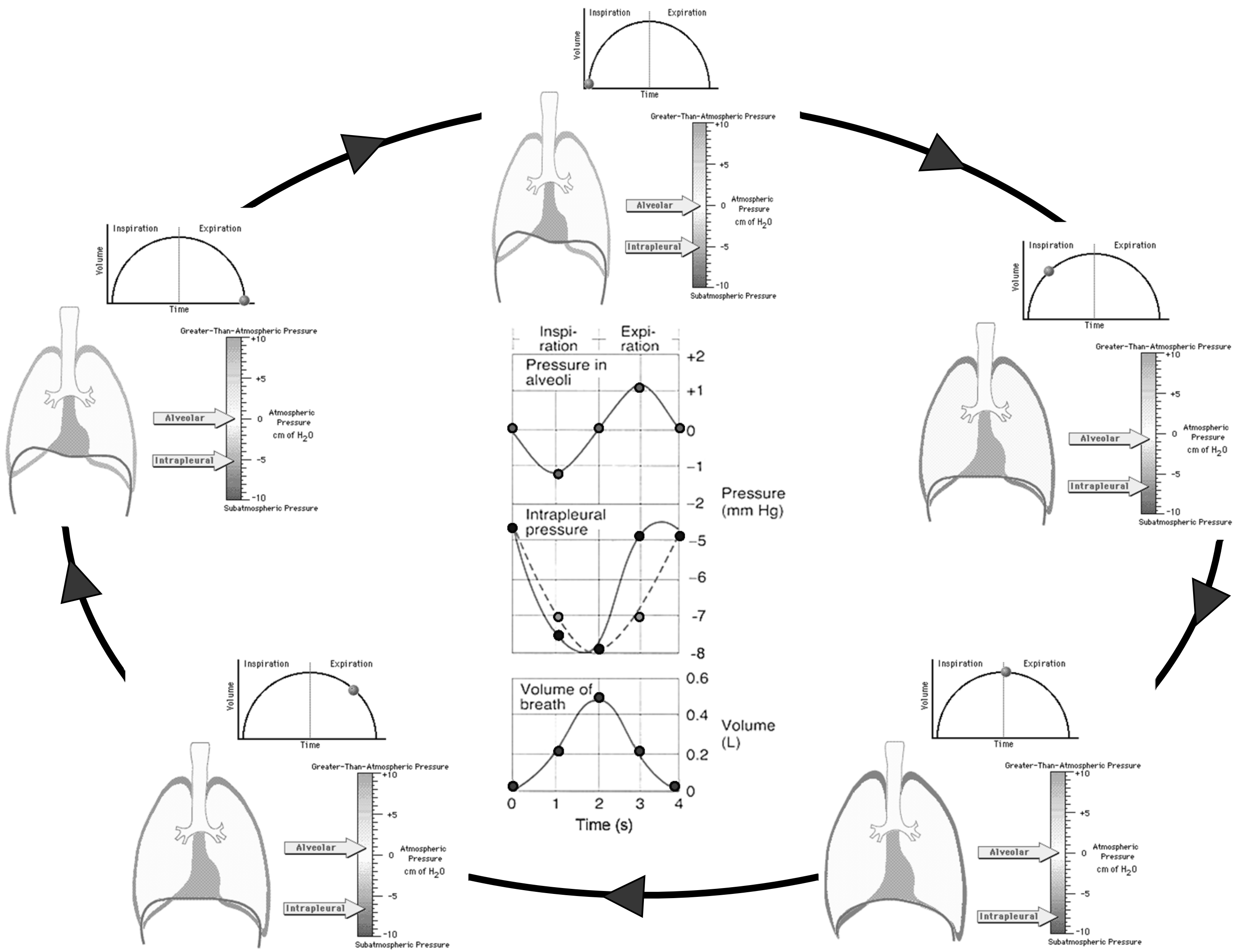


Transmural Pressure Across the Lung Wall in Dynamic Status

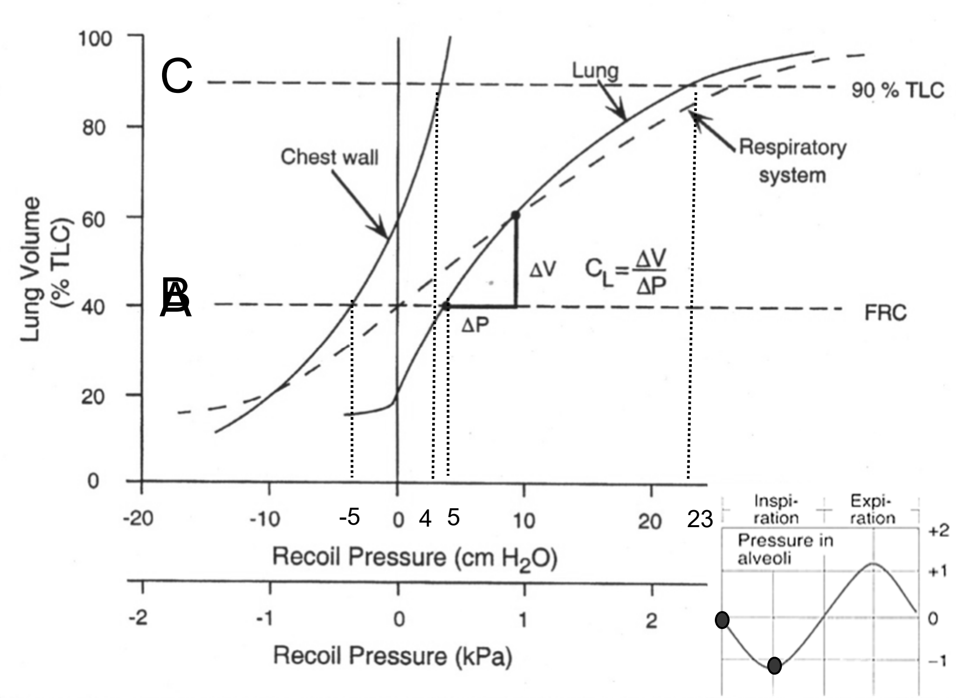


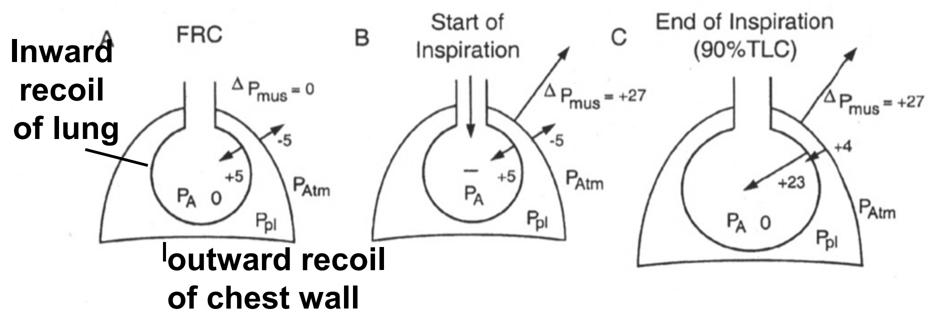


The Mechanics of Quiet Breathing



P-V Relationships and Schematic Events of Resp. Cycle





A: Pw= -5 = Ppl – 0 $\rightarrow$ Ppl = -5

P_L = 5 = Pal – Ppl = Pal – (-5)

$\rightarrow$ Pal = 0 $\rightarrow$ No airflow

B: Pw = Ppl – Pmus – Pbs = -5

= Ppl – (-27) $\rightarrow$ Ppl = -32

P_L = 5 = Pal – Ppl = Pal – (-32)

$\rightarrow$ Pal = -27 $\rightarrow$ insp

C: Pw = Ppl – Pmus – Pbs = 4

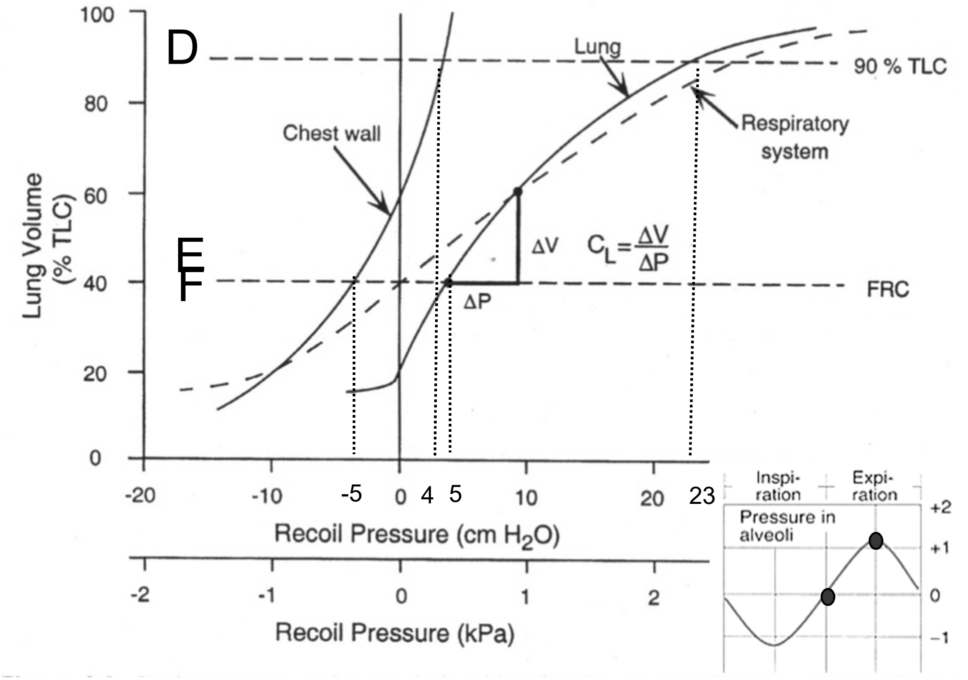
= Ppl – (-27) $\rightarrow$ Ppl = -23

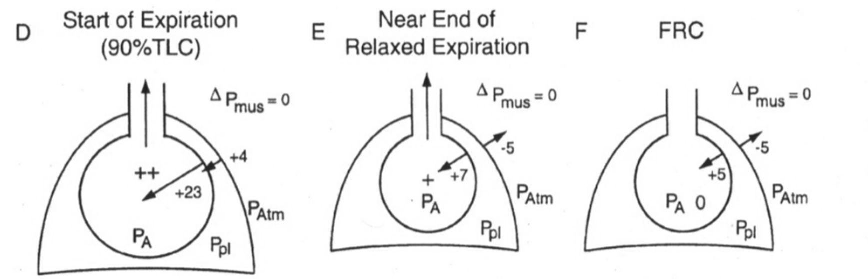
P_L = Pal – Ppl = 23 = Pal – (-23)

$\rightarrow$ Pal = 0 $\rightarrow$ No airflow

* Pal < 0 before Vol. Changes

P-V Relationships and Schematic Events of Resp. Cycle





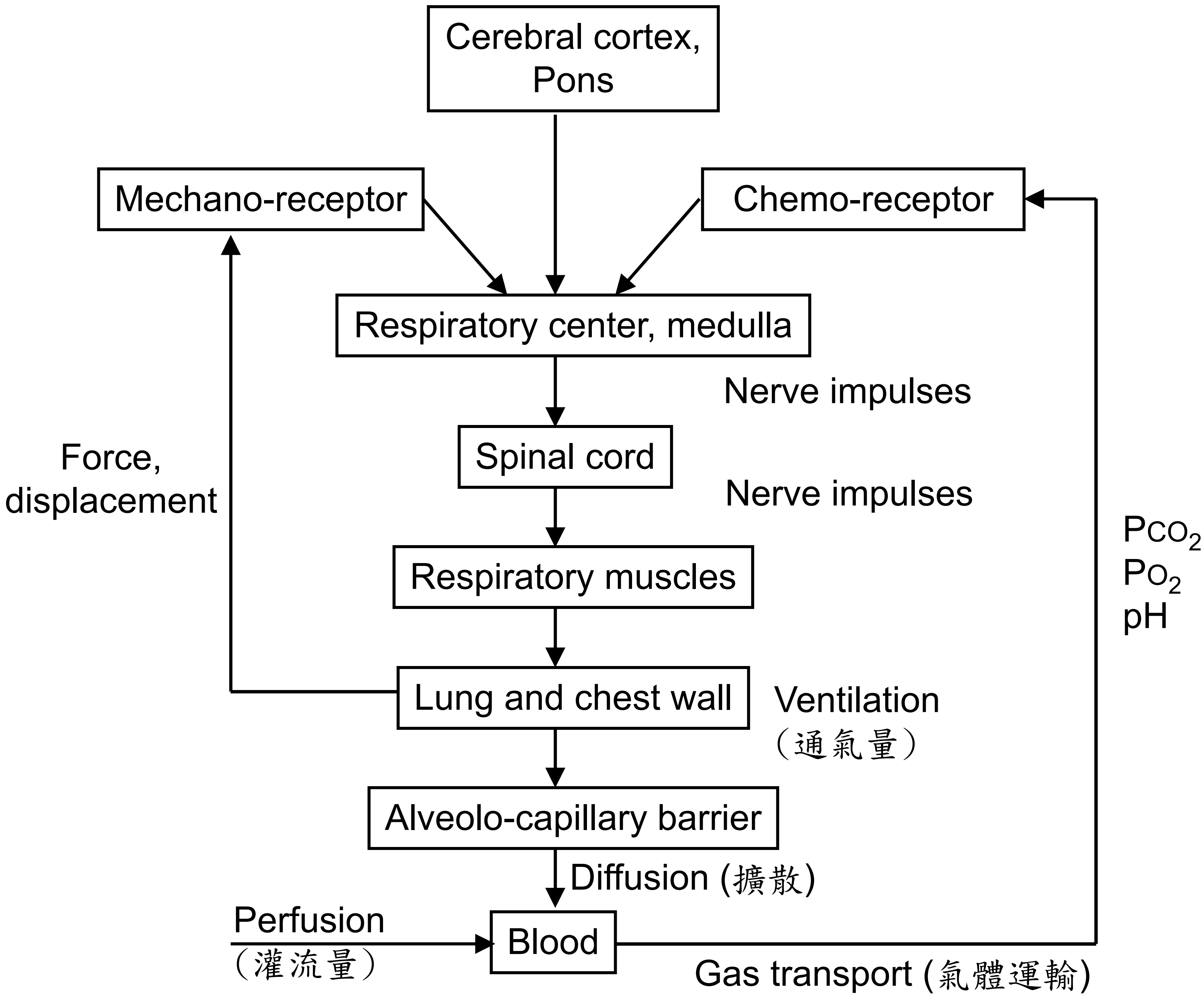
D: Pw = Ppl – Pmus – Pbs = 4
= Ppl – (0) → Ppl = 4
P_L = Pal – Ppl = 23 = Pal – (4)
→ Pal = 27 >> Patm → Exp. fast

F: Pw= -5 = Ppl – 0 → Ppl = -5
P_L = 5 = Pal – Ppl = Pal – (-5)
→ Pal = 0 → No airflow

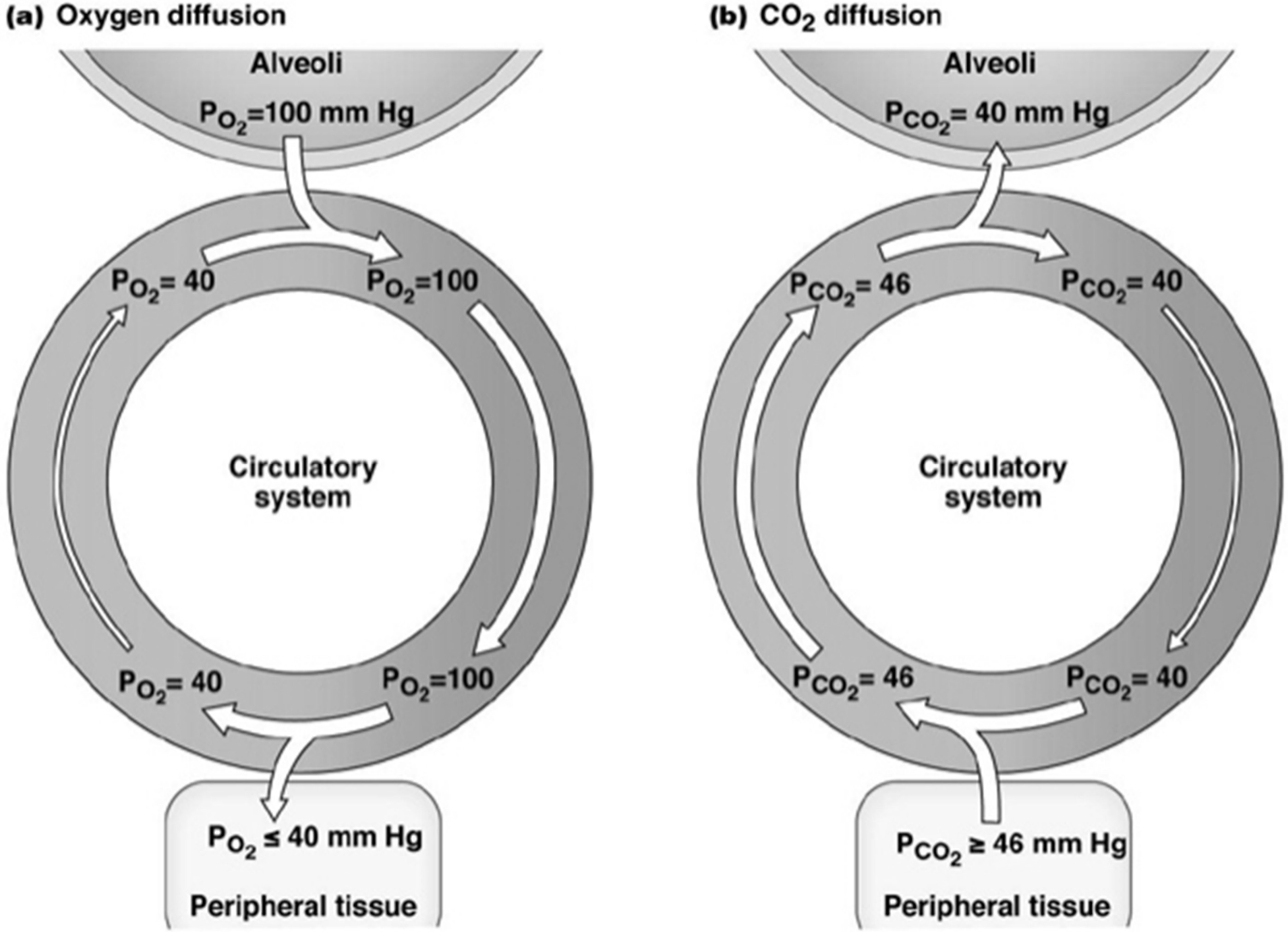
E: Pw = Ppl – Pmus – Pbs = -5
= Ppl – (0) → Ppl = -5
P_L = 7 = Pal – Ppl = Pal – (-5)
→ Pal = 2 > Patm → Exp. slower

Outline

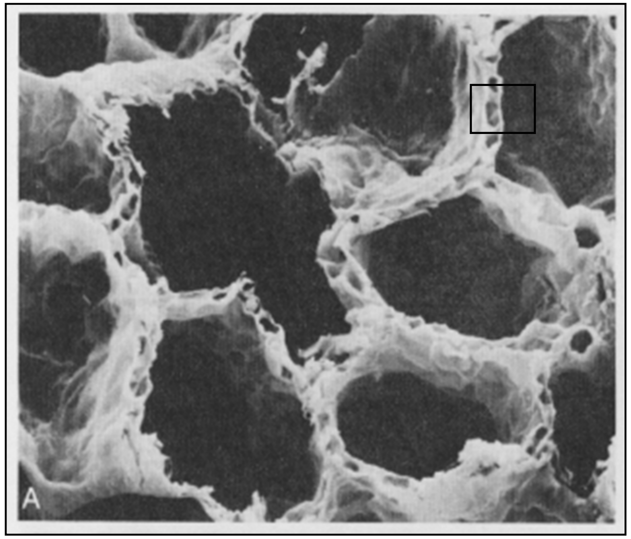
- Background
- Structure and function
- Ventilation
- Perfusion and ventilation/perfusion ratio
- Static/Dynamic respiratory mechanics
- Diffusion（擴散）and gas transport（氣體運輸）
- Neural control of respiration
- Chemical control of respiration
- Acid-base balance
- Examples: exercise and high altitude adaptation

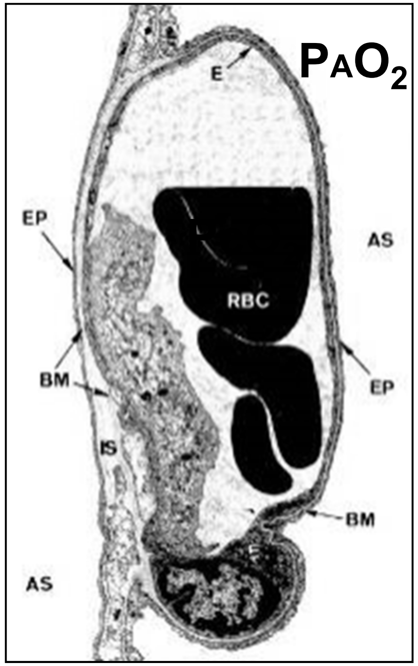

Cerebral cortex, Pons
Mechano-receptor
Chemo-receptor
Respiratory center, medulla
Nerve impulses
Spinal cord
Nerve impulses
Force, displacement
Respiratory muscles
P_{CO_2}
P_{O_2}
pH
Lung and chest wall
Ventilation (通氣量)
Alveolo-capillary barrier
Diffusion (擴散)
Perfusion (灌流量)
Blood
Gas transport (氣體運輸)

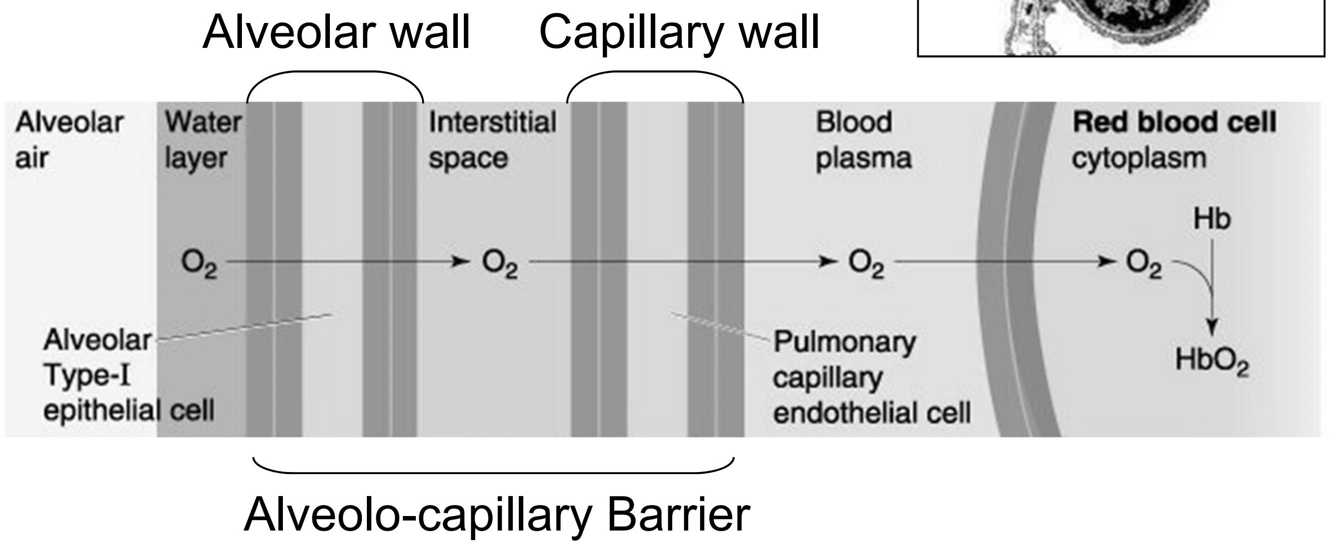
Diffusion and Gas Transport



Alveolo-Capillary Barrier

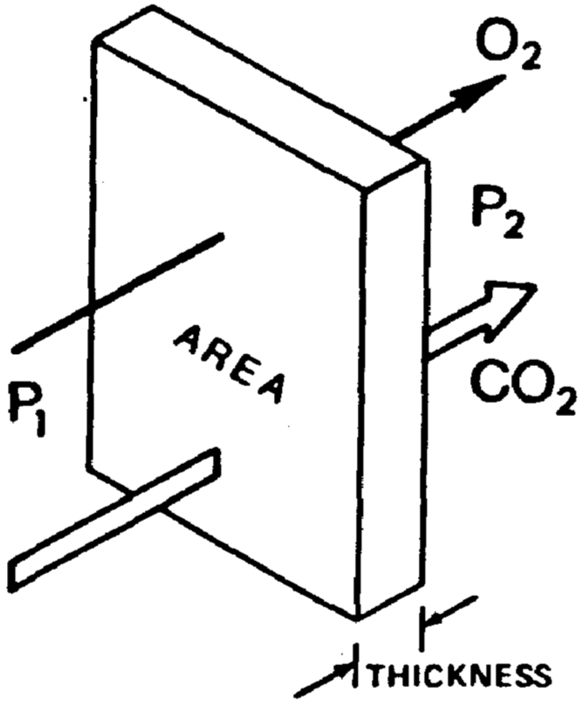






Diffusion

- The movement of molecules from a area in which they are highly concentrated to a area in which they are less concentrated
- Fick′s law



Fick's law:

$$\dot{V}gas \propto \frac{A}{T}.D.(P_1 - P_2)$$

$$D \propto \frac{Sol}{\sqrt{M.W.}}$$

A: surface area
D: diffusion constant
T: thickness

Diffusion Capacity

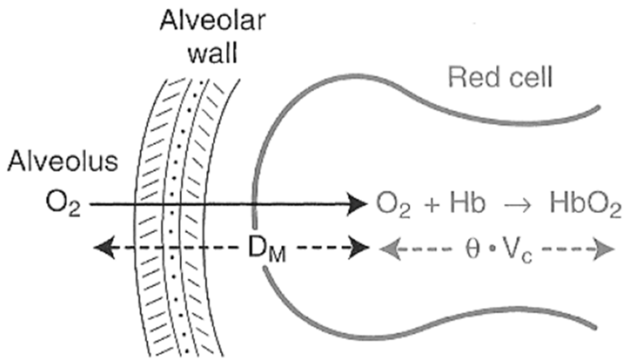
- Purpose: to measure the ability of gases to diffuse across the alveolar-capillary membrane (blood-gas barrier)
- Lung diffusion capacity (D_L):

$$D_L = \frac{\dot{V}_{gas}}{P_1 - P_2} \propto \frac{A \times D}{T} \text{ (from Fick's law)}$$

- Two components of the lung diffusing capacity:
  - ✓ Alveolar (capillary) membrane properties (D_M)
  - ✓ Chemical combination with hemoglobin: time to react with Hb

Θ = reaction rate with Hb

V_C = capillary blood volume



$$\frac{1}{D_L} = \frac{1}{D_M} + \frac{1}{\theta \cdot V_c}$$

Diffusion Capacity

- Measurement: CO
  - ✓ Affinity to hemoglobin (Hb) is very high
  - ✓ 0.1% of CO for about 1/2 min (low toxic)

$$\frac{1}{D_L} = \frac{1}{D_M} + \frac{1}{\theta \cdot V_c}$$

- The normal value of $D_L CO$ is about 25 ml/min/mmHg

Physiologic Changes That Alter Diffusion Capacity

- Reducing diffusion capacity

  Fick's law: $\dot{V}_{gas} \propto A \times (P_1\text{-}P_2) \times D/T$

  ✓ Decrease surface area: emphysema

  ✓ Thickening of alveolar wall: pulmonary fibrosis

- Increasing diffusion capacity

  ✓ Exercise

  ✓ Polycythemia

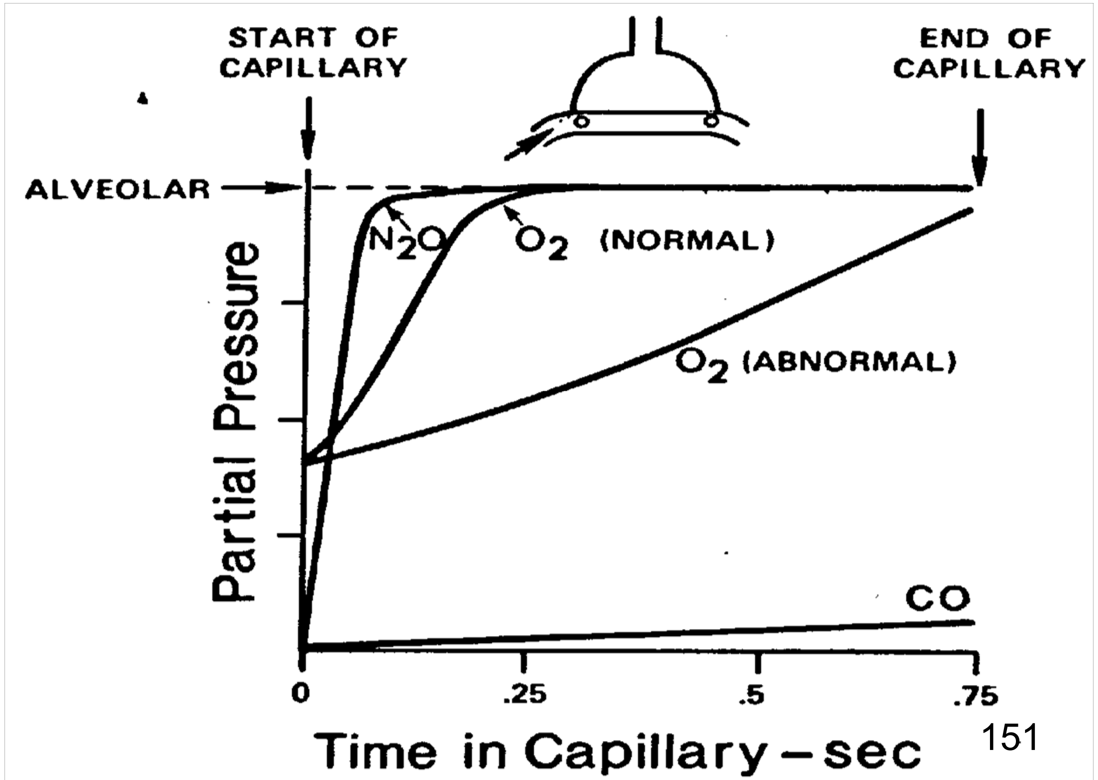
$$\frac{1}{D_L} = \frac{1}{D_M} + \frac{1}{\theta \cdot V_c}$$

Θ = reaction rate with Hb

V_C = capillary blood vol.

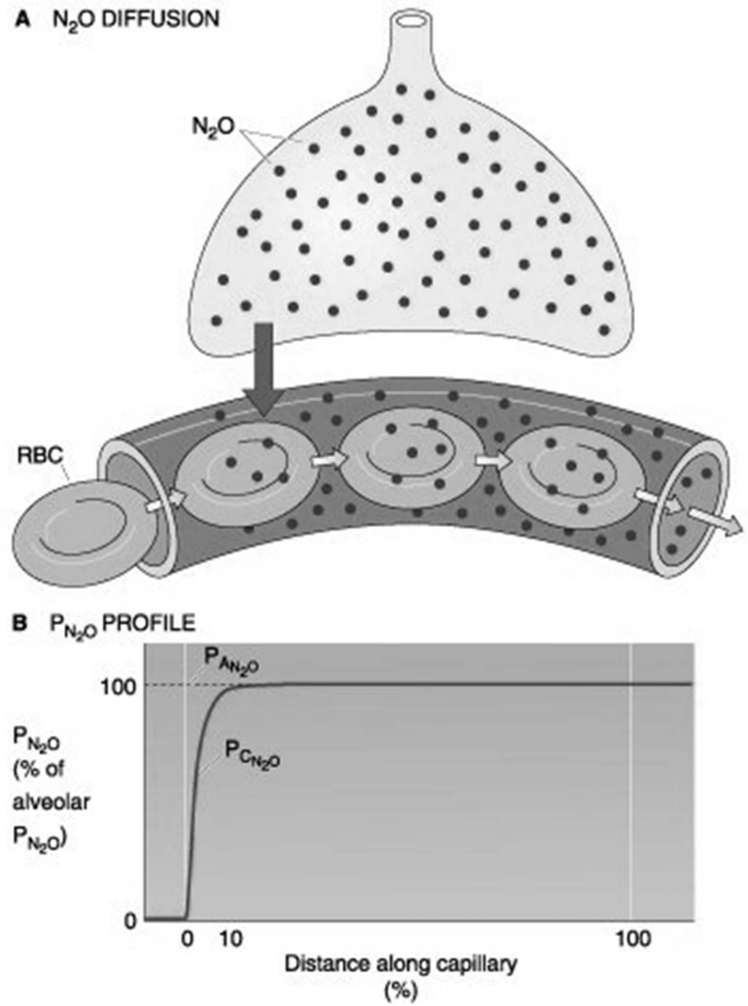
Capillary Transit Time

- Capillary transit time is ~0.75 sec
- If diffusion defects, exercise results in poor oxygenation of blood
- N_2O: perfusion-limited
- CO: diffusion-limited



Perfusion-limited Gas

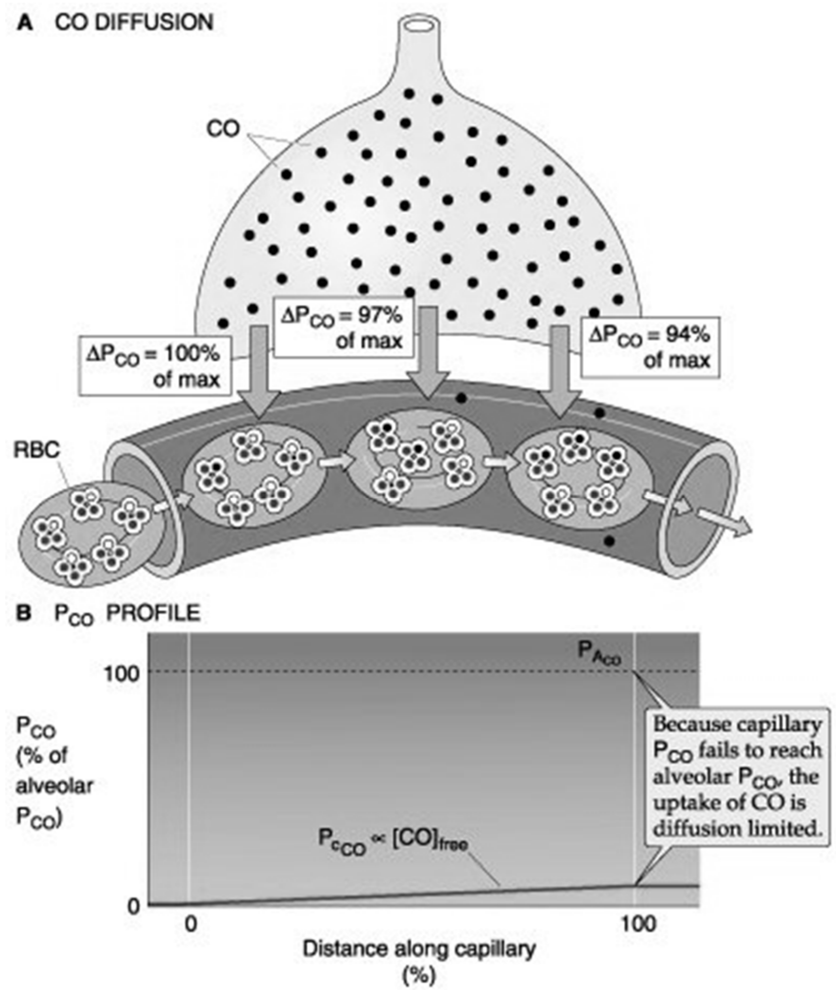
- Uptake of nitrous oxide (N_2O) is perfusion-limited
- Hb does not bind N_2O
- P_AN_2O and P_cN_2O rapidly equilibrate
- To increase uptake of a perfusion-limited gas, blood flow must increase



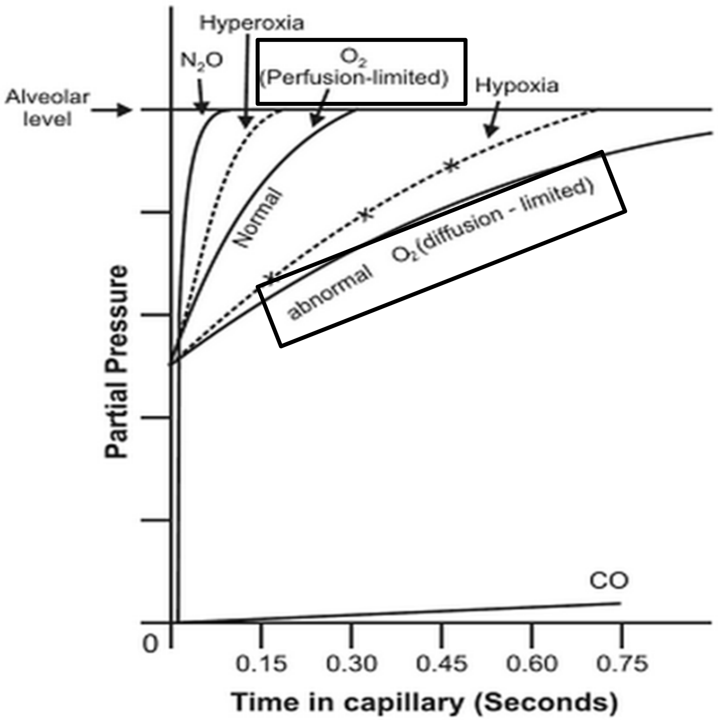
Diffusion-limited Gas

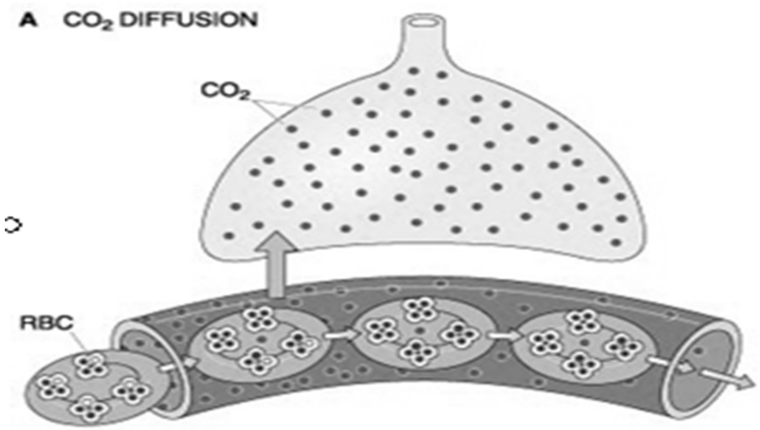
- Uptake of CO is diffusion-limited
- High affinity of Hb for CO
- No equilibration
  $P_cCO \approx P_vCO \approx 0$

- To increase uptake of a diffusion-limited gas, ΔP must increase



Diffusion and Perfusion Limitations

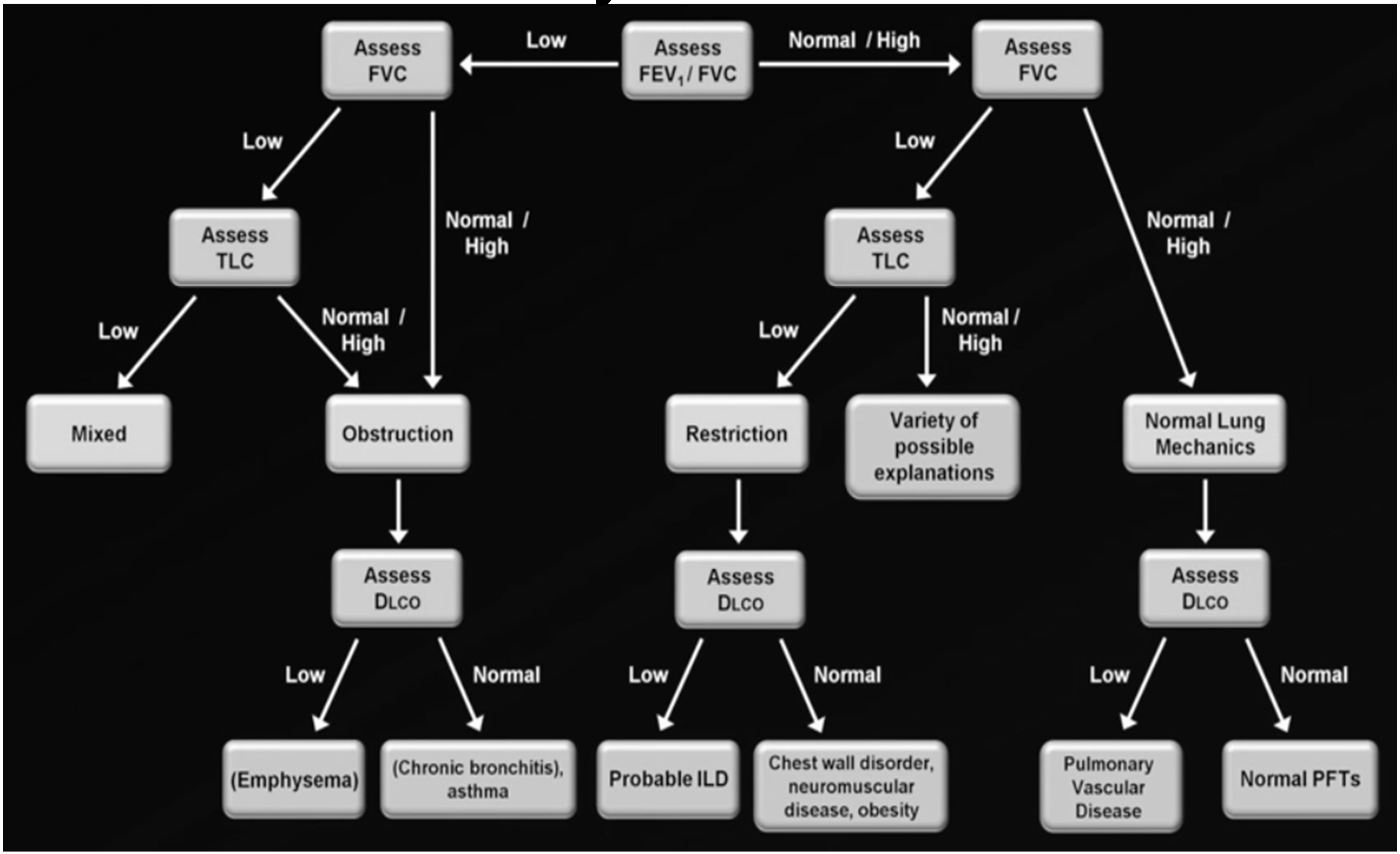




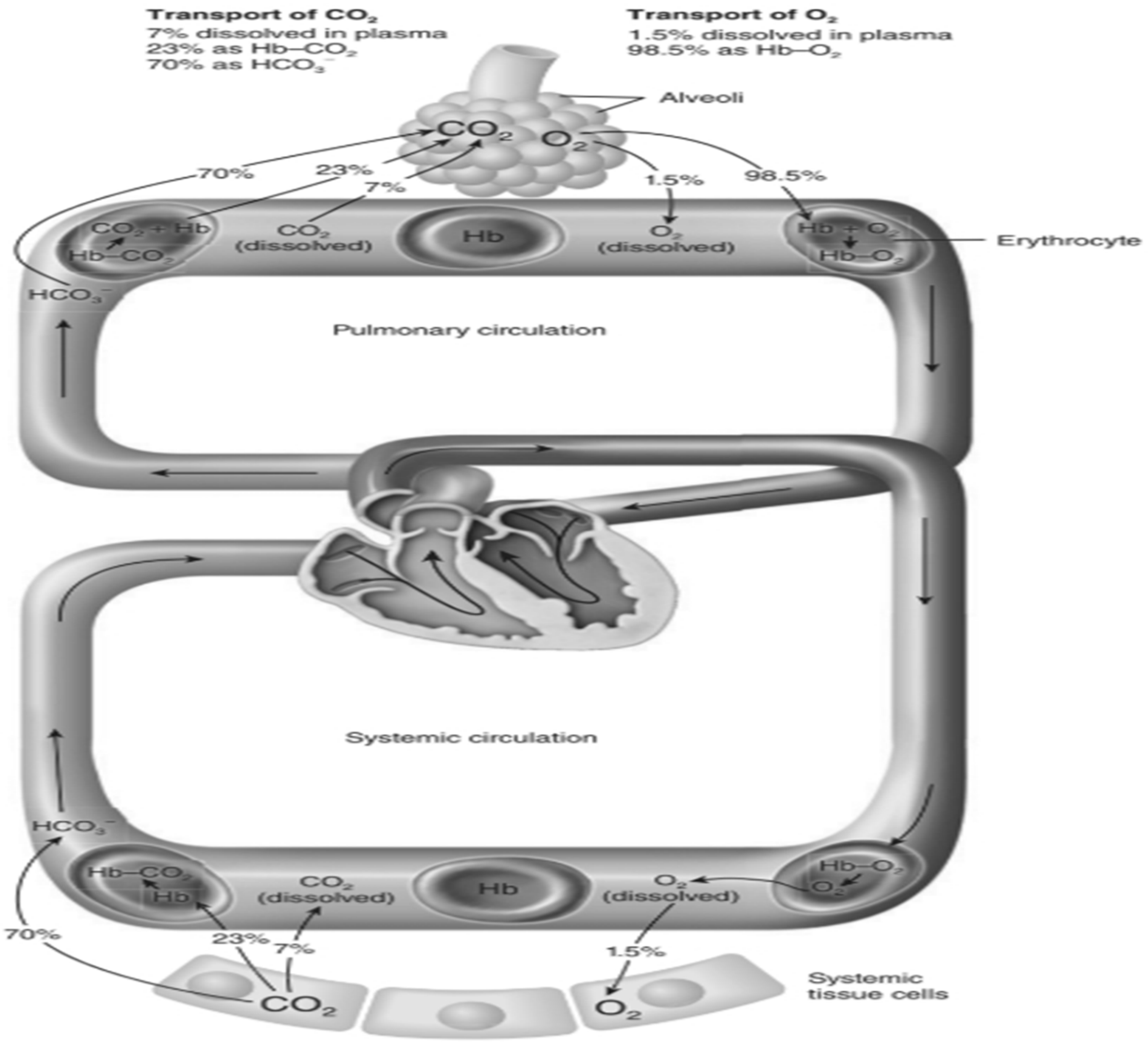
- O_2 is normally perfusion-limited gas
  - ✓ E.g., exercise
- If D_Lo_2 is decreased in disease, O_2 becomes more diffusion limited

- CO_2 exchange is much less affected when perfusion increases or D_L decreases

Interpretation of Pulmonary Function Test

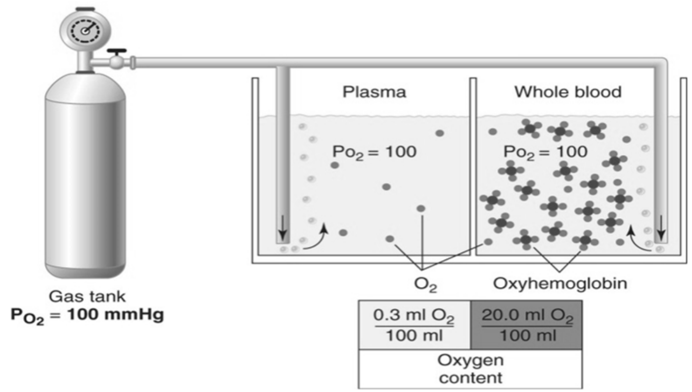


Transport of O_2 and CO_2



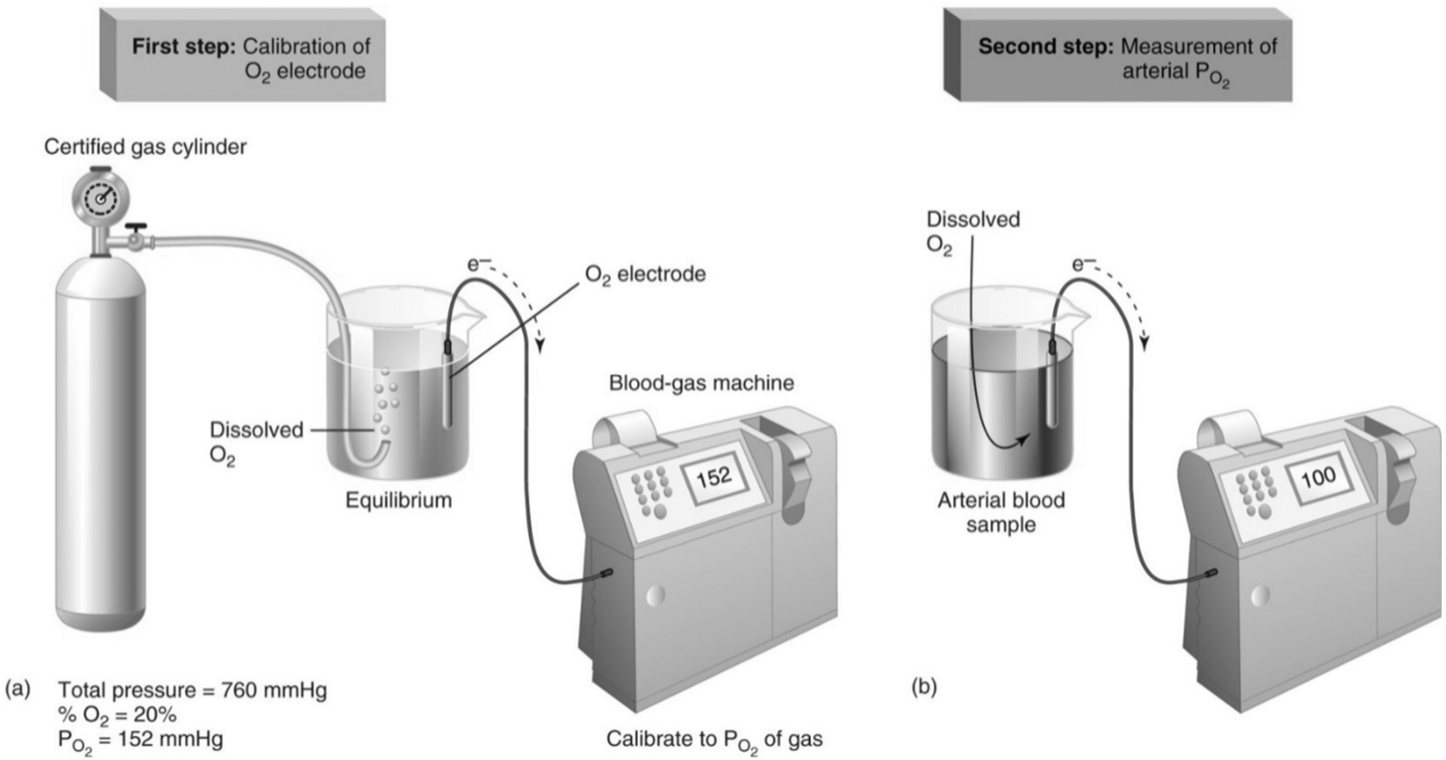
Oxygen Transport

- Two ways of O_2 carried in blood
  - ✓ Dissolved O_2 in plasma (<5%)
  - ✓ Bound to hemoglobin (Hb) (> 95%)
- Dissolved O_2
  - ✓ Normal arterial blood with a Po_2 of 100 mmHg contains 0.3 ml dissolved O_2/100 ml of blood
- Bound to hemoglobin (Hb)
  - ✓ Oxygen dissociation curve and factors affecting the curve



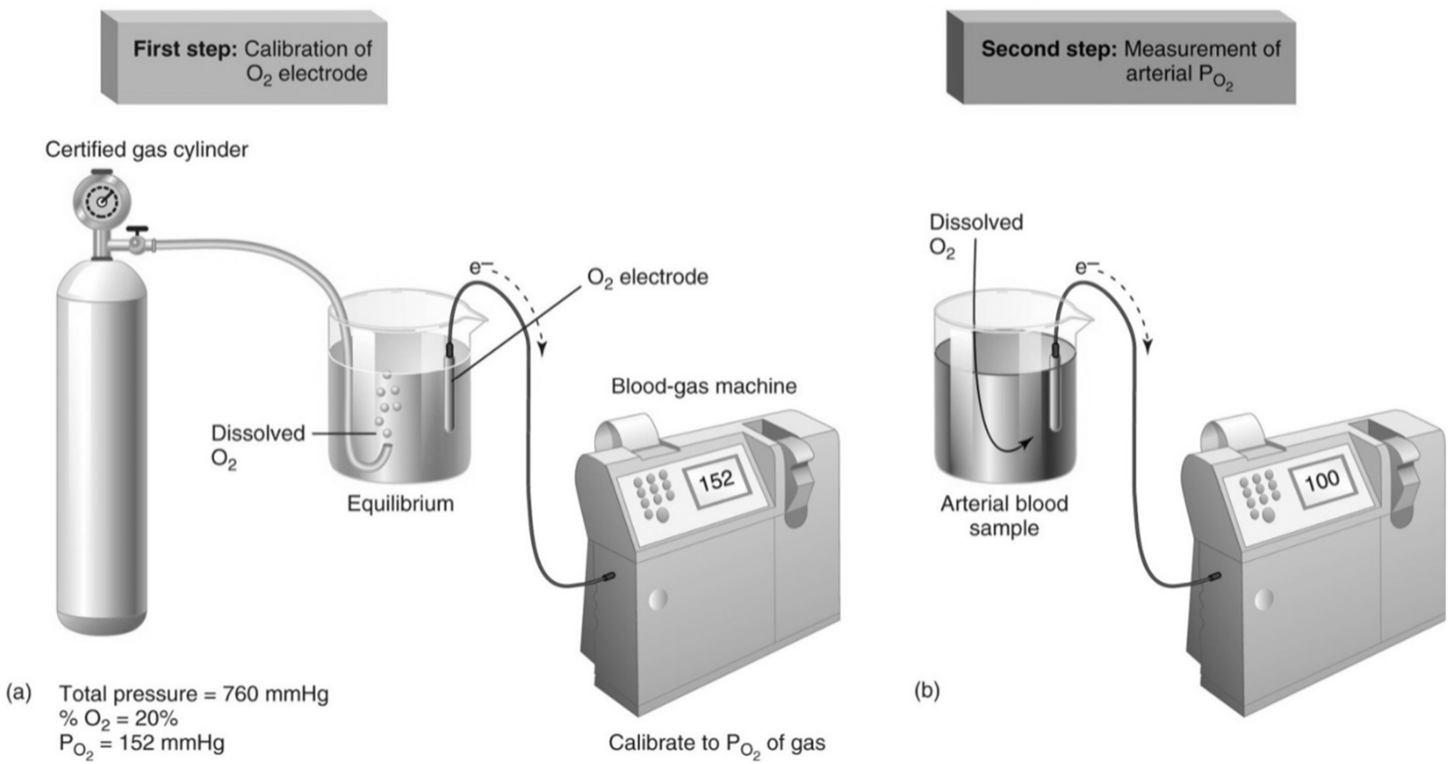
Blood Gas Measurement

- Arterial blood gas (ABG): a sample of arterial blood, which provides you with Pao_2, $Paco_2$, pH
- Uses an oxygen electrode



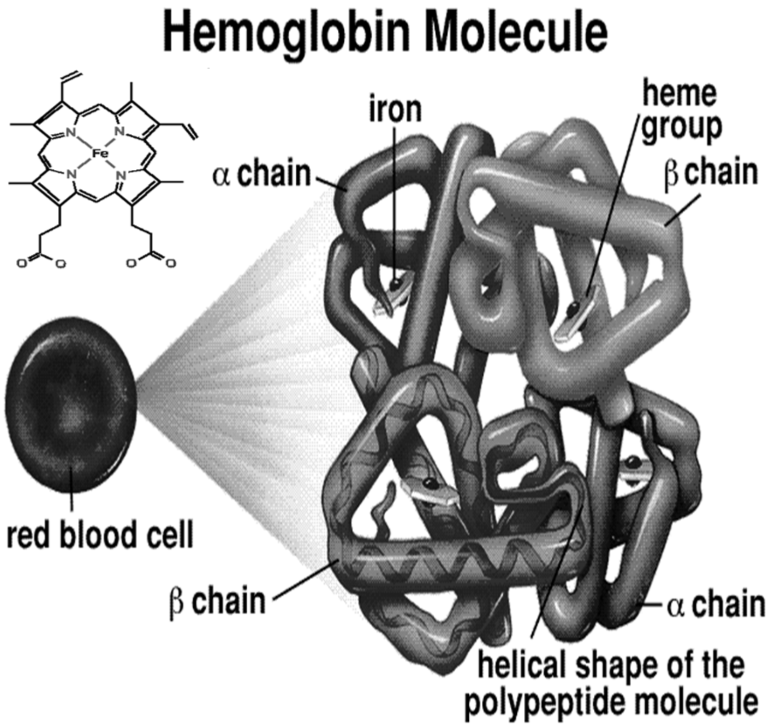
Blood Gas Measurement

- Only measures oxygen dissolved in the blood plasma
  - ✓ Not measure oxygen in red blood cells
  - ✓ Anemia dose not affect P_ao_2, $P_aco_{2,}$ but decrease P_vO_2
    - ➢anemia → tissue hypoxia → Pvo_2, Svo_2 decreases



O_2 Bound to Hb

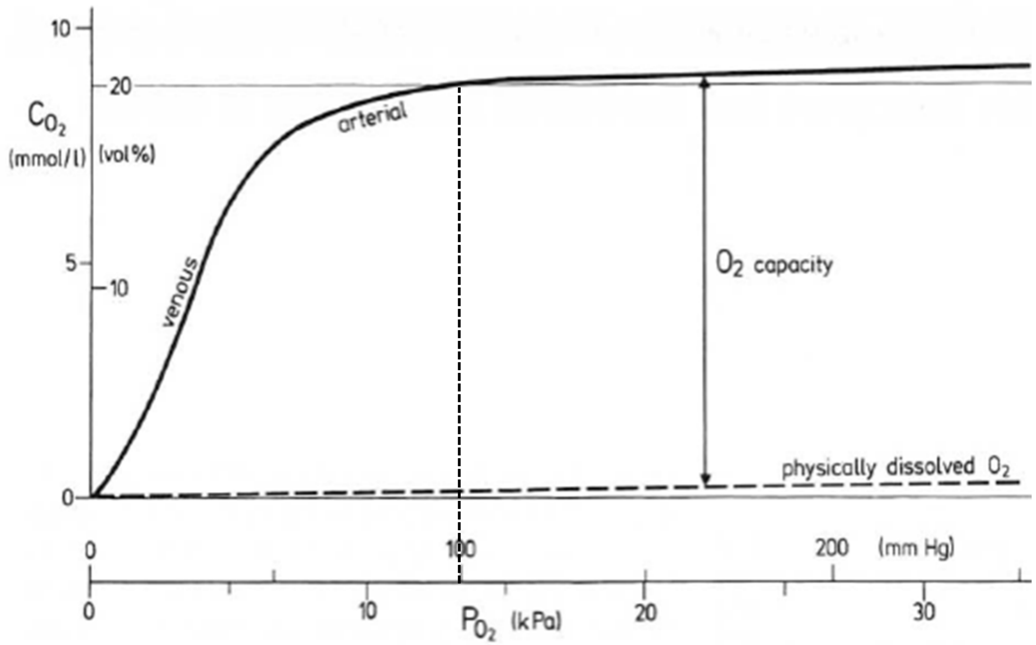
- Hemoglobin (Hb): heme + globin



- ✓ a [α(2):β(2)] tetrameric hemoprotein that is carried by erythrocytes
- ✓ an iron atom in heme is responsible for the binding of oxygen
- ✓ each Hb combines with 4 O_2 molecules

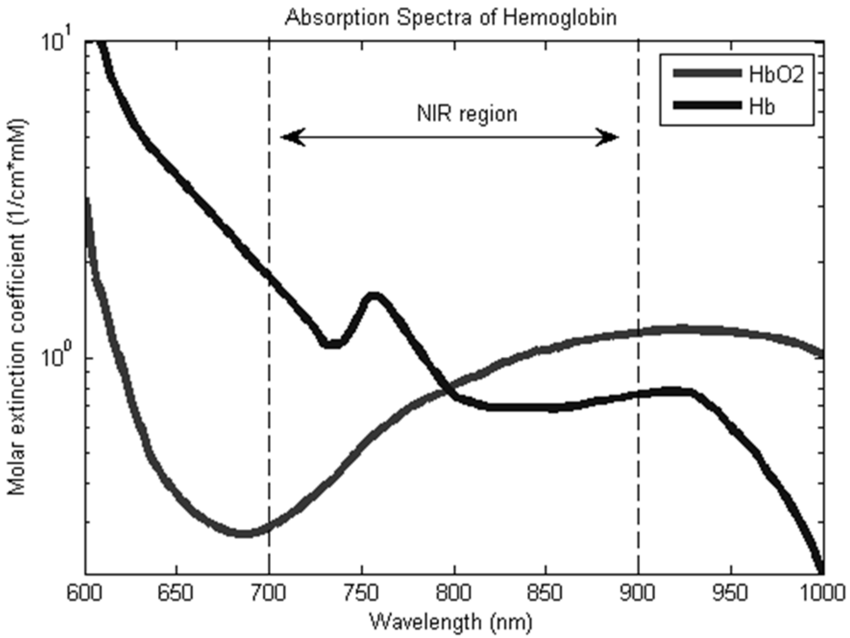
O_2 Bound to Hb

- O_2 capacity: max. amount of O_2 that can combine with Hb
  =15 g of Hb/100ml blood x 1.39 ml/g of Hb
  = 20.9 ml /100ml blood
- O_2 capacity varies individually
- % saturation =
  $\frac{\text{Hb-bound } O_2}{O_2 \text{ Capacity}}$ X 100%
- O_2 dissociation curve



What does pulse oximeter measure?

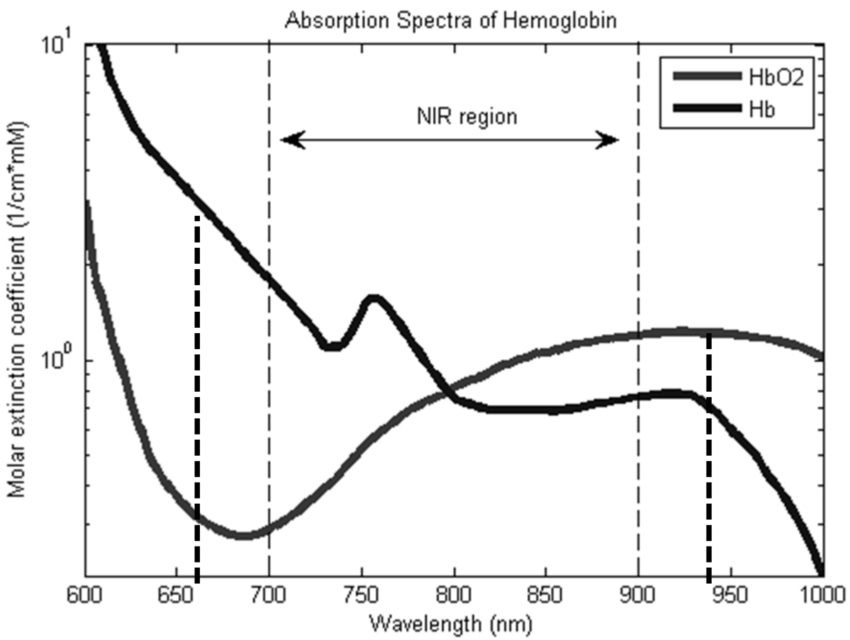
1. O_2 dissolved in the blood plasma
2. O_2 bound with hemoglobin



What does pulse oximeter measure?

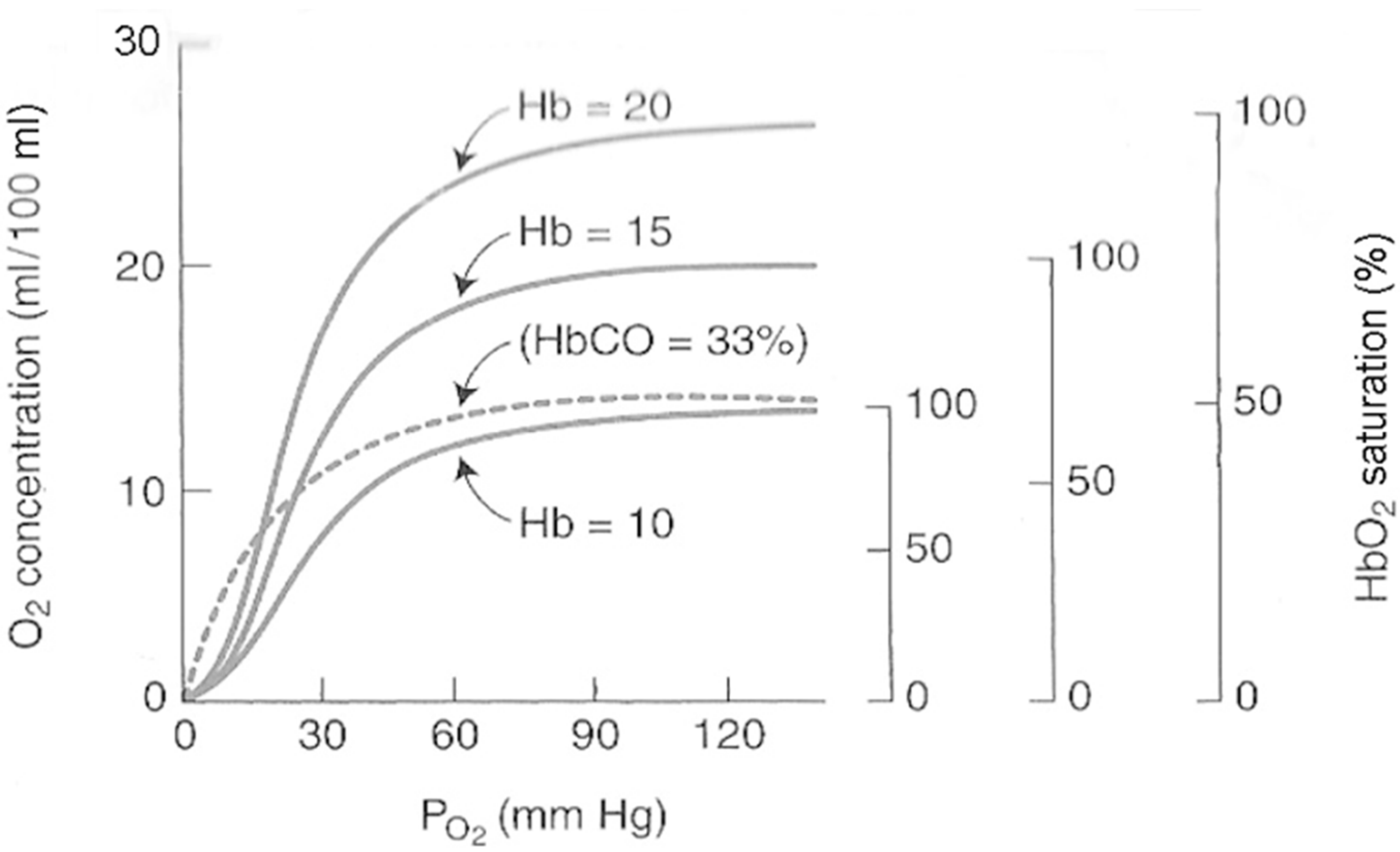
1. O_2 dissolved in the blood plasma
2. O_2 bound with hemoglobin

* Pulse oximeter:
Measures the absorbance of A940 (HbO_2) and A660 (Hb) to calculate saturation of peripheral O_2 (SpO_2)

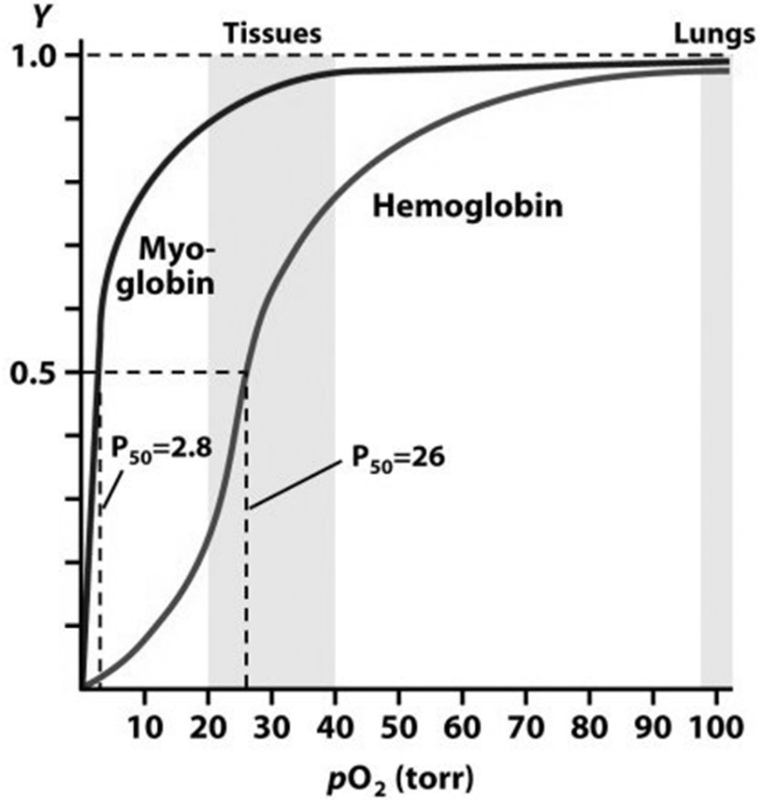


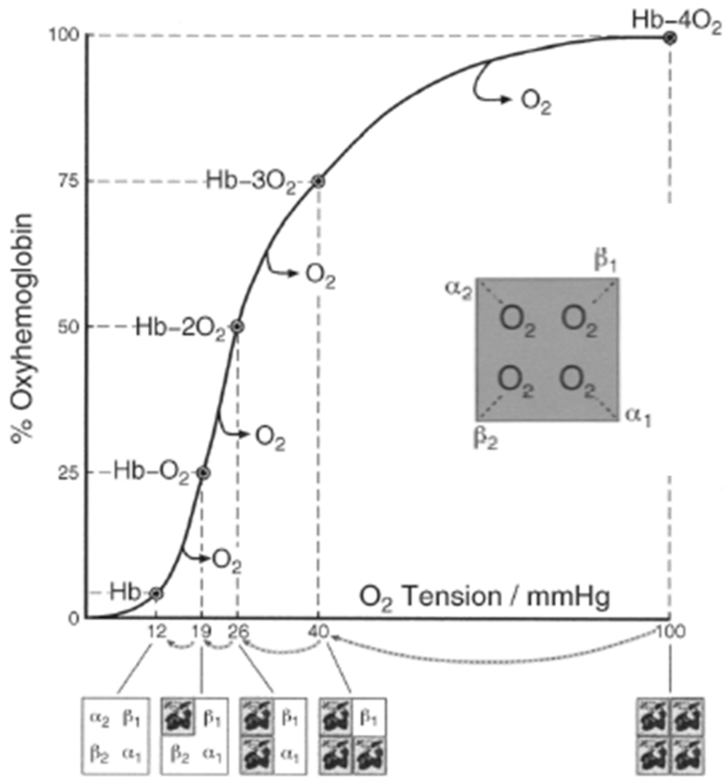
O_2 Concentration & Saturation in Anemia

- Anemia (貧血): low O_2 concentration (low O_2 capacity) but normal O_2 saturation



Cooperative Interactions

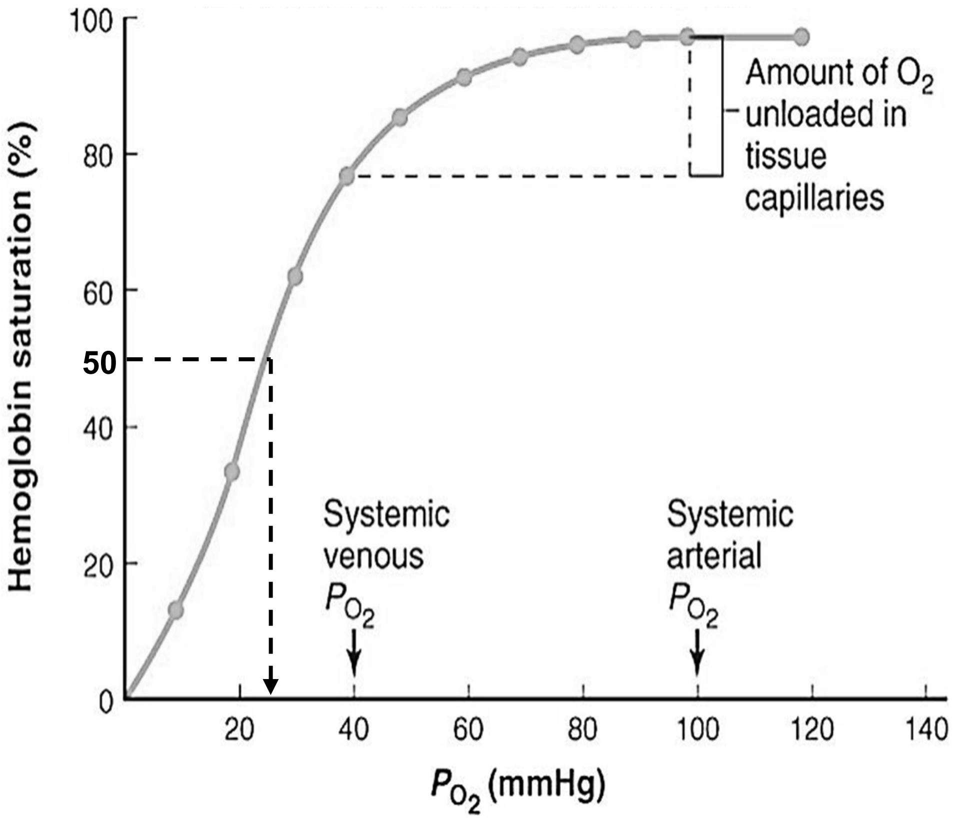




- Myoglobin: monomer; Hemoglobin: tetramer
- Stamp analogy: cooperativity

O_2 Bound to Hb

- Characteristics of O_2 dissociation curve



✓ Po_2=100 mmHg (alveolar)
→ near saturated (95~98 %)
→ affinity good

✓ Po_2 ~ 70-100 mmHg
→ little change
→ affinity changed little

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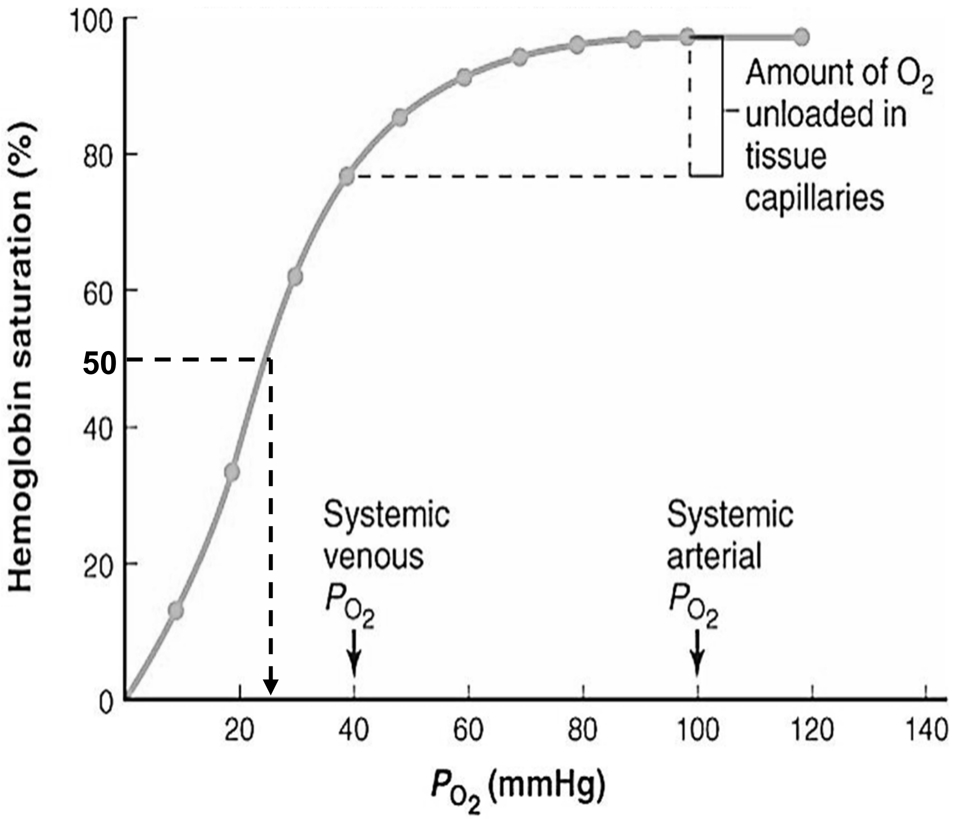
川普染疫後血氧一度低於94% 張上淳：代表曾為重症

最新更新：2020/10/07 18:10

O_2 Bound to Hb

- Characteristics of O_2 dissociation curve



✓ Po_2=100 mmHg (alveolar)
→ near saturated (95~98 %)
→ affinity good

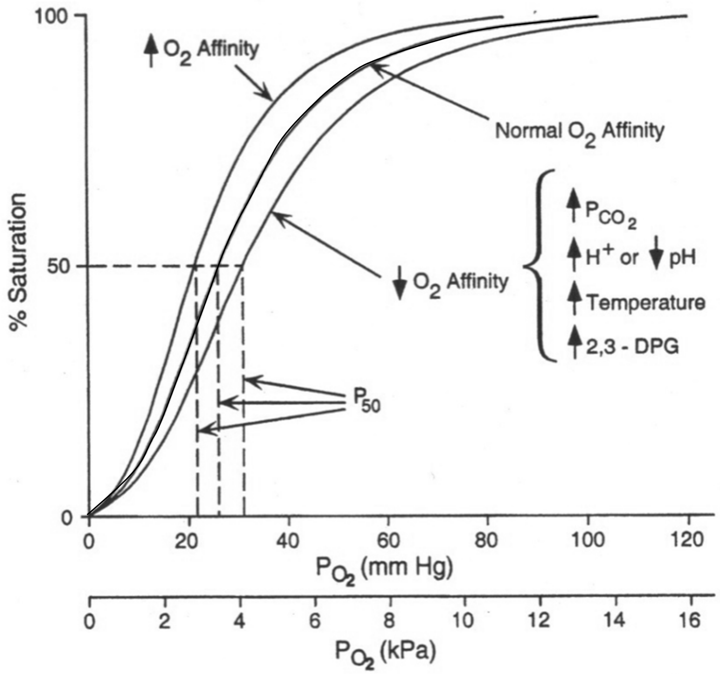
✓ Po_2 ~ 70-100 mmHg
→ little change
→ affinity changed little

✓ Po_2 ~ 40-50 mmHg (tissue)
→ unload O_2 easily
→ affinity decrease

P_{50}: Po_2 at 50% of saturation
- Higher P_{50} → lower affinity

O_2 Bound to Hb

- Factors affecting O_2 saturation curve



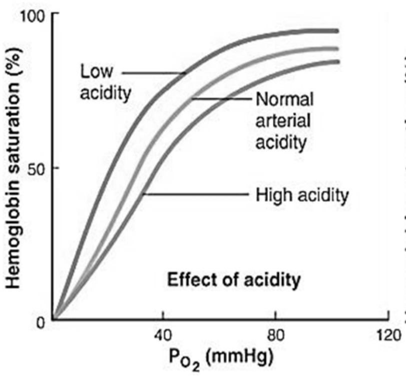
Right shift of curve (O_2 unloading):
→P_{50} ↑ (↓ affinity)
✓ ↑ P_{CO2}: Bohr effect
✓ ↑ H^+ (↓ pH)
✓ ↑ body temp
✓ ↑ 2,3-DPG (diphosphoglycerate): formed during anaerobic metabolism of RBC
  - high altitude, hypoxia, chronic lung disease

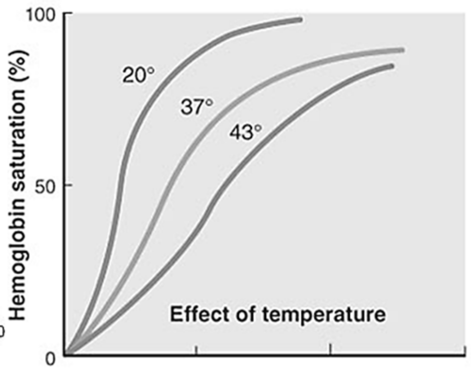
Example: exercise

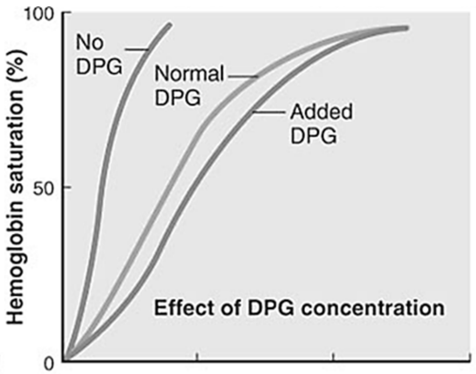
Factors Affecting O_2 Bound to Hb

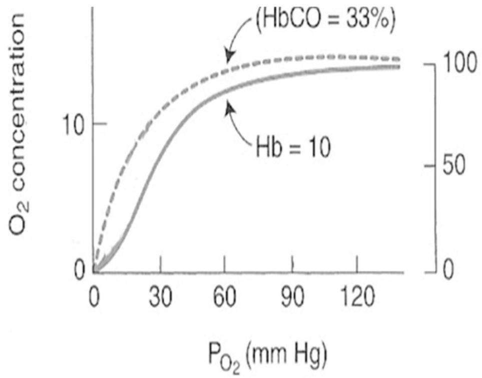
Right shift of curve
- P_{50} increase
- Lower affinity
- Easier "unloading" O_2

Left shift of curve
- P_{50} decrease
- Higher affinity
- Easier "loading" O_2









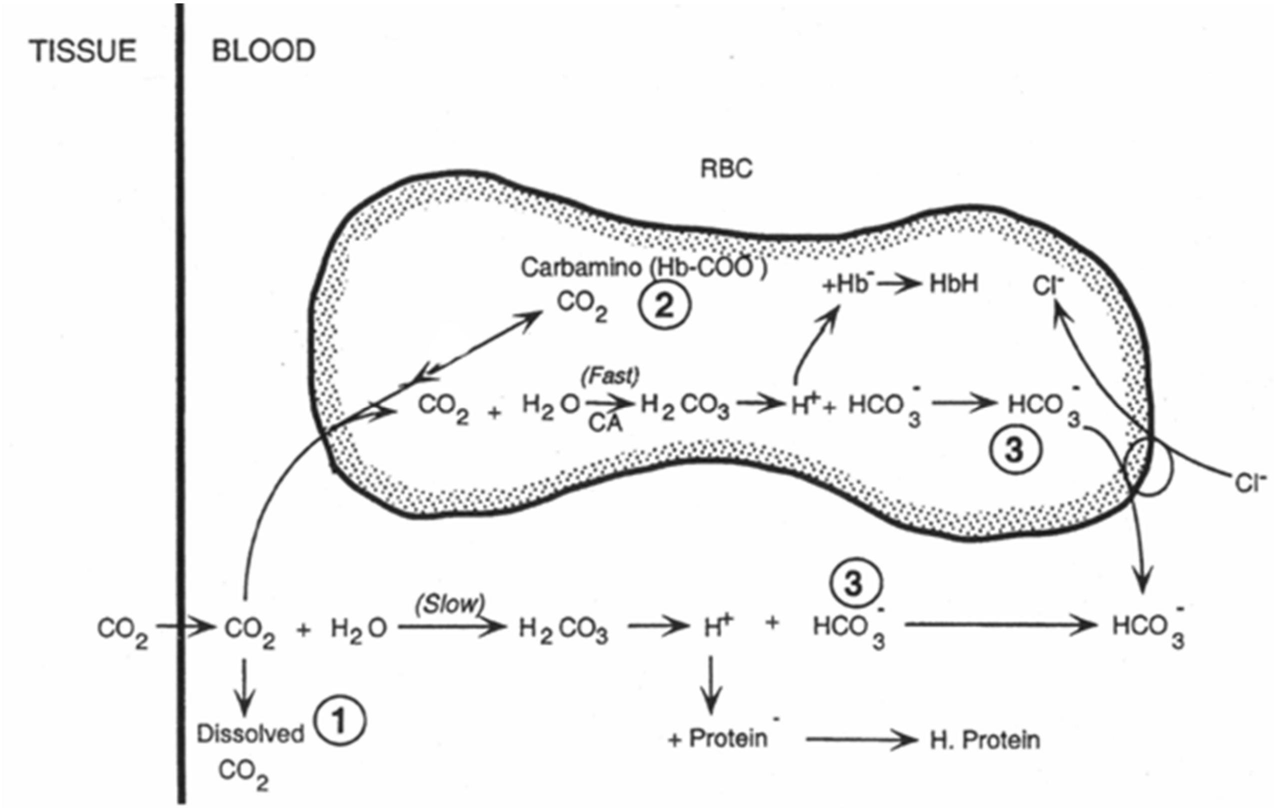
Hb bound to CO

→ Left shift of curve

CO_2 Transport

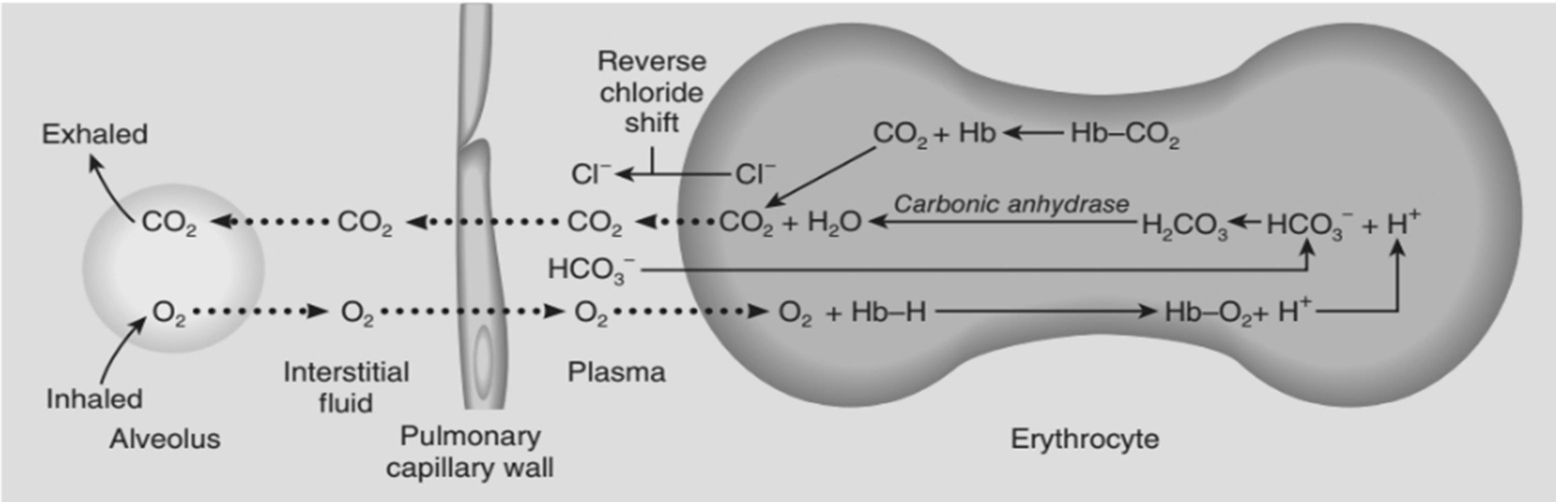
- Three ways of CO_2 carried in blood: transported from the body cells back to the lungs
  - ✓ Dissolved CO_2 in plasma (7-10%)
  - ✓ Carbamino Hb (15-30%): bound to hemoglobin (Hb)
  - ✓ Bicarbonate (HCO_3^-) (60-70%):
    - ➢ most transport in plasma
    - ➢ most formed in RBC by carbonic anhydrase

CO_2 Transport

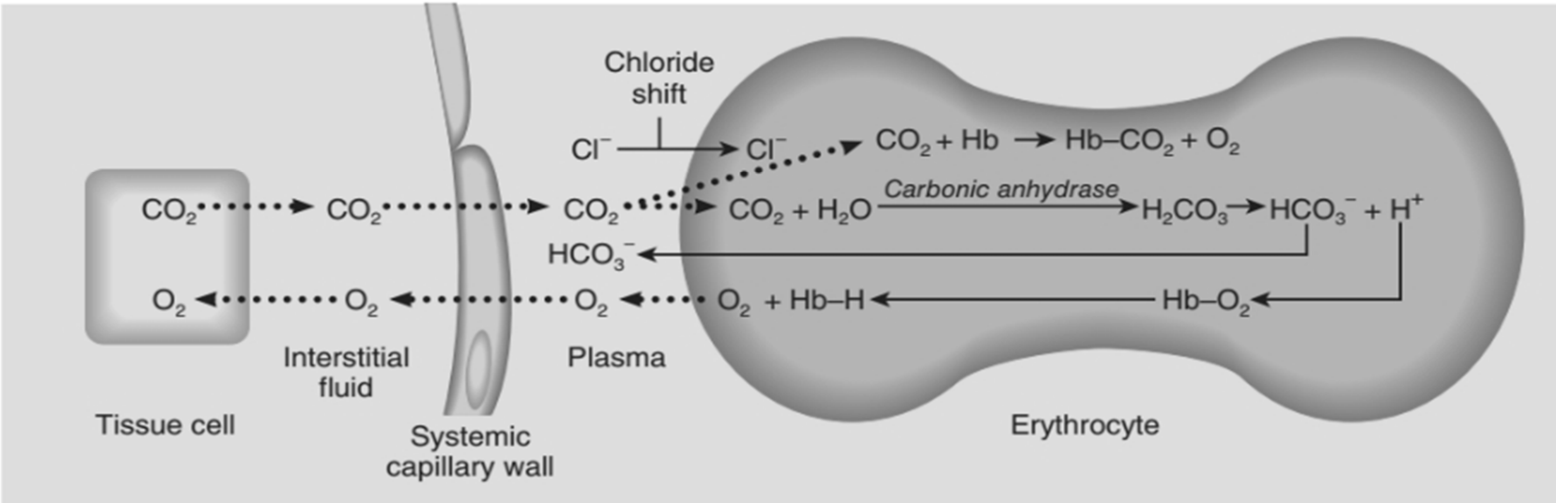


- H^+ + Hb: to maintain the blood pH
- CA: carbonic anhydrase
- Chloride shift: exchange with HCO_3^- to maintain electrical neutrality

CO_2 Transport

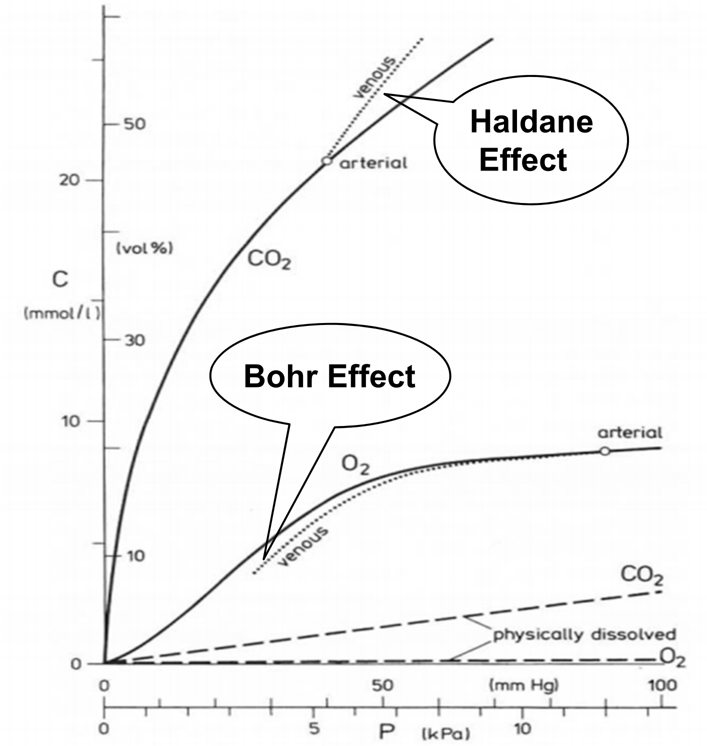


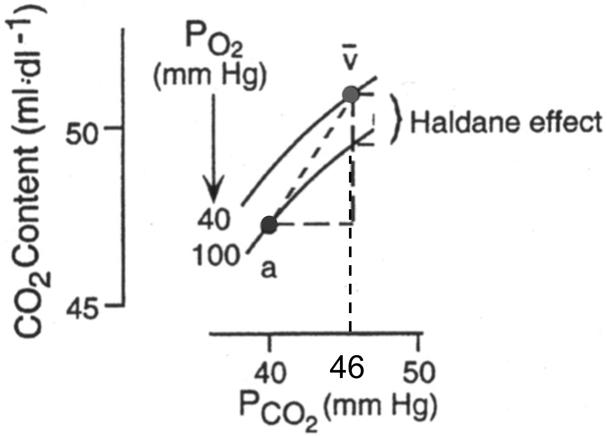
(a) Exchange of O_2 and CO_2 in pulmonary capillaries (pulmonary gas exchange)



(b) Exchange of O_2 and CO_2 in systemic capillaries (systemic gas exchange)

CO_2 Equilibrium Curve





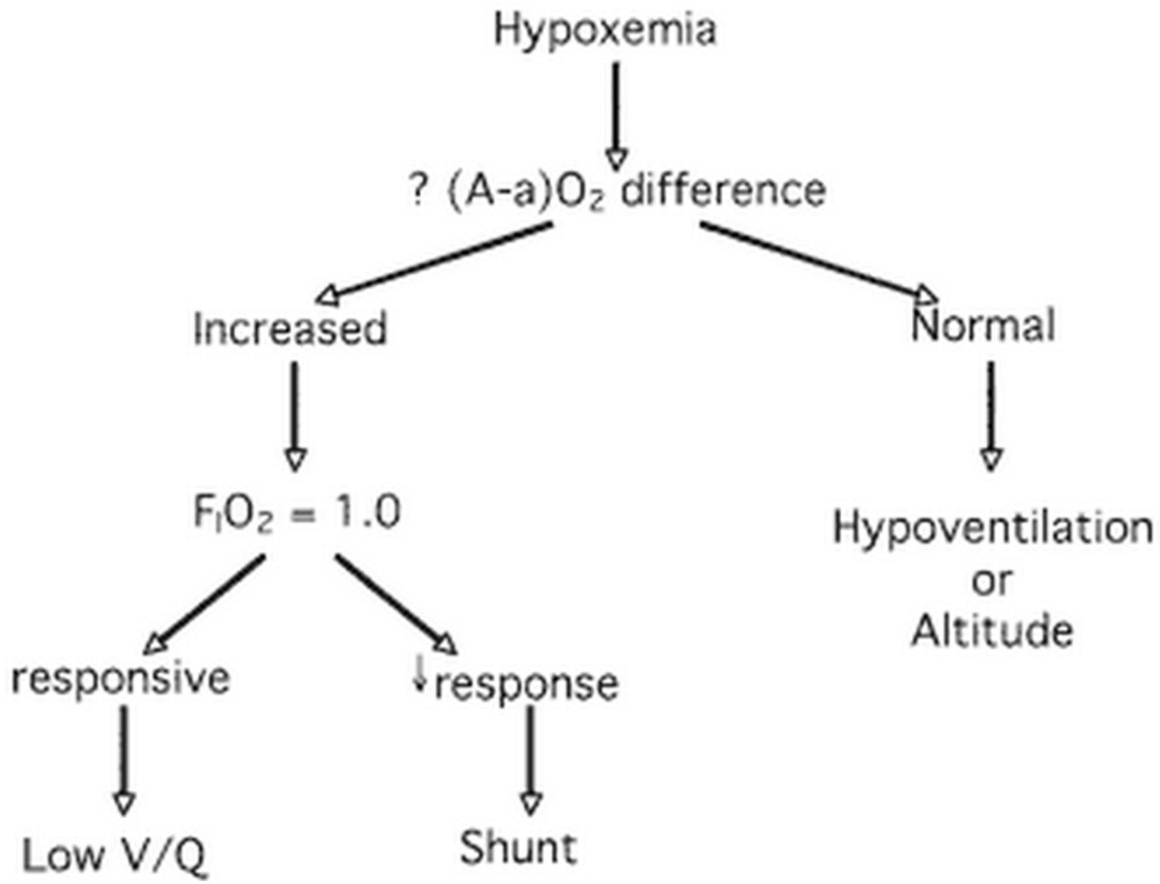
- Haldane effect: deoxygenation of Hb increases its affinity for CO_2 (curve left shift)

* Bohr effect: P_{CO2} decreases the binding affinity of O_2 to hemoglobin (curve right shift)

Assessment of Arterial Hypoxemia

Causes:

- Low inspired Po_2
- Hypoventilation
- Shunt
- Diffusion limitation
- $\dot{V}/Q$ mismatch



Individual	Pao_2 (mmHg)	$Paco_2$ (mmHg)	Cao_2 (ml /dl blood)	Sao_2 (%)
A	100	40	20	97
B	100	40	10	97
C	120	20	20	98
D	600	40	22	100
E	45	35	20	90

Assume Individual A is a normal human breathing room air at sea level. Indicate what might be responsible for the blood gas values in the four other individuals.

Cao_2: O_2 concentration (ml O_2/100 ml blood); Sao_2: percent O_2 saturation

B: Anemia or CO poisoning
C: Hyperventilation
D: Breathing air enriched in O_2

Individual	Pao_2 (mmHg)	$Paco_2$ (mmHg)	Cao_2 (ml /dl blood)	Sao_2 (%)
A	100	40	20	97
B	100	40	10	97
C	120	20	20	98
D	600	40	22	100
E	45	35	20	90

Cao_2: O_2 concentration (ml O_2/100 ml blood); Sao_2: percent O_2 saturation

If he is at sea level,
P_{AO_2} = 0.21 x (760-47) – (35/0.83) = 107.6 >> 45 mmHg
→ Diffusion problem due to lung pathology

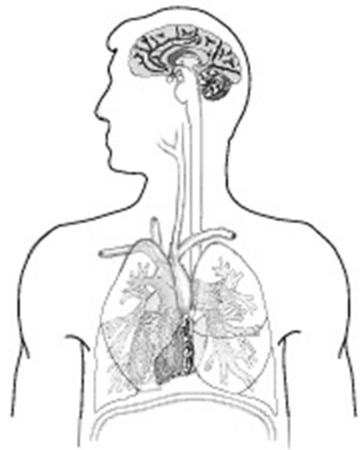
If he is at high altitude level (Barometric pressure = 500 mmHg),
P_{AO_2} = 0.21 x (500-47) – (35/0.83) = 53 mmHg
→ Due to high altitude

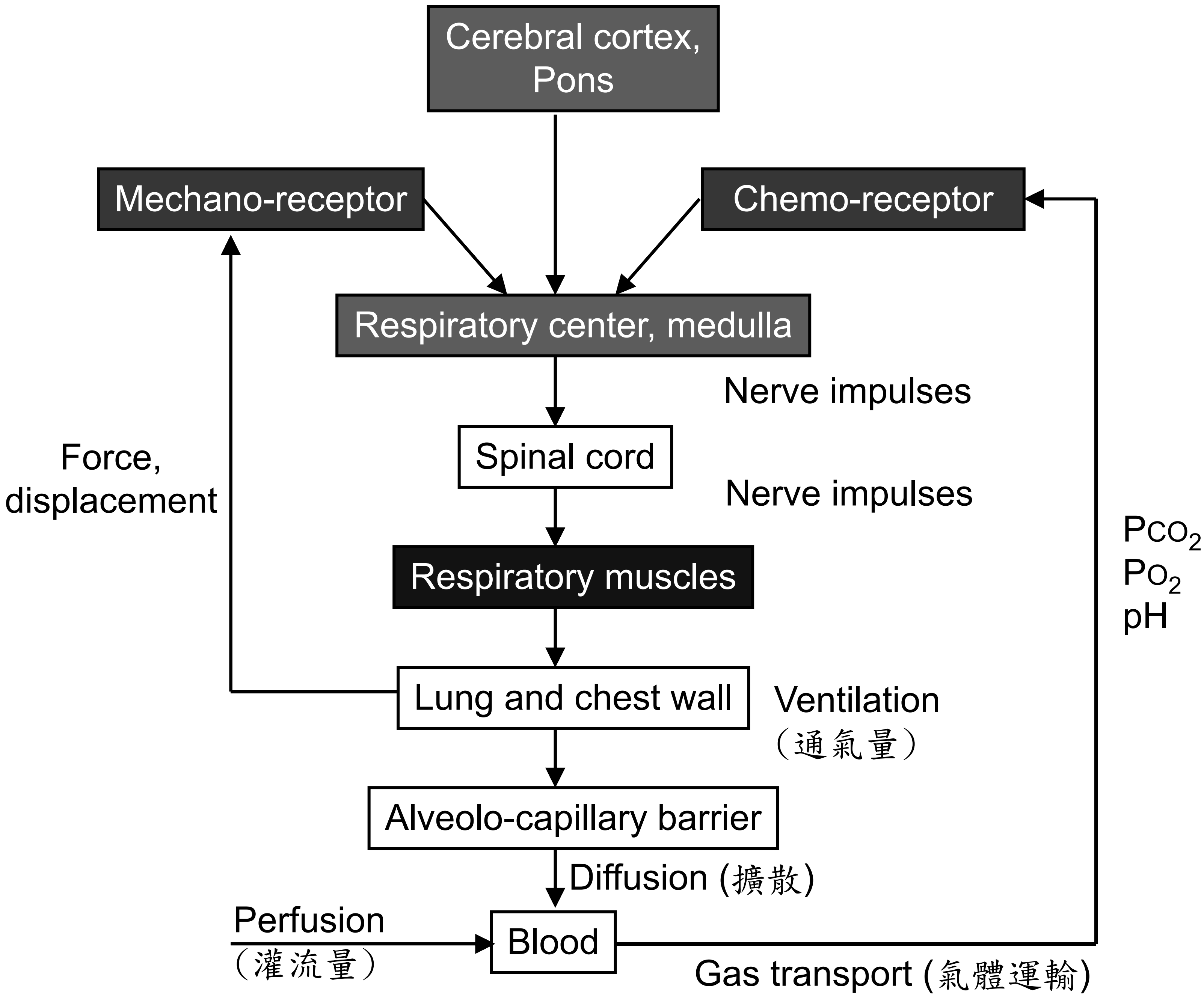
Outline

- Background
- Structure and function
- Ventilation
- Perfusion and ventilation/perfusion ratio
- Static/Dynamic respiratory mechanics
- Diffusion and gas transport
- Neural control of respiration（呼吸的神經調控）
- Chemical control of respiration
- Acid-base balance
- Examples: exercise and high altitude adaptation

Control of Respiration

- Three components of resp. control system:
  - ✓ Sensors (receptors): e.g. mechanoreceptor
  - ✓ Central controller: e.g. medulla
  - ✓ Effectors: e.g. resp. muscle
- Central control of breathing
  - ✓ Origination: cause of resp. drive in the brain
  - ✓ Rhythmicity: how do neurons integrate to give insp./exp.
  - ✓ Adjustment: meet different conditions, e.g. exercise



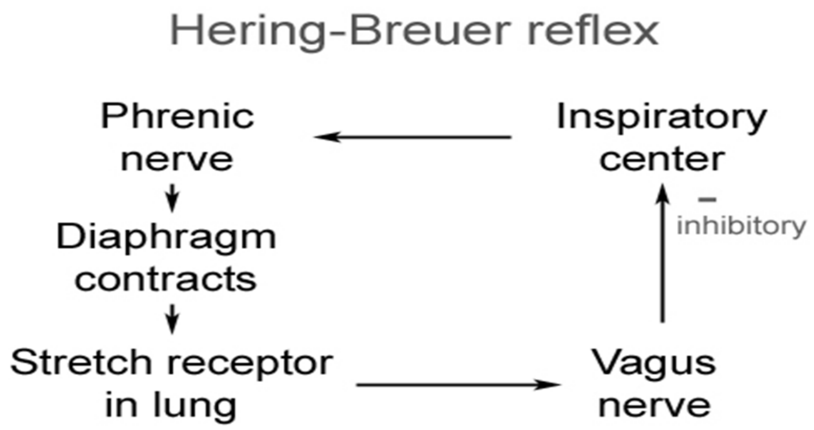

Cerebral cortex,
Pons
Mechano-receptor
Chemo-receptor
Respiratory center, medulla
Nerve impulses
Spinal cord
Nerve impulses
Force,
displacement
Respiratory muscles
P_{CO_2}
P_{O_2}
pH
Lung and chest wall
Ventilation
(通氣量)
Alveolo-capillary barrier
Diffusion (擴散)
Perfusion
(灌流量)
Blood
Gas transport (氣體運輸)

Receptors

- Chemoreceptors
  - ✓ Peripheral: carotid bodies; aortic bodies
  - ✓ Central: medulla
- Lung receptors
  - ✓ Rapidly adapting receptor (irritant R.)
    - ➢ Located between airway epithelial cell
    - ➢ Stimulated by noxious gas; cigarette smoke; inhaled dusts; cold air
    - ➢ Effect: hyperpnea; bronchoconstriction; coughing; mucous secretion

Receptors

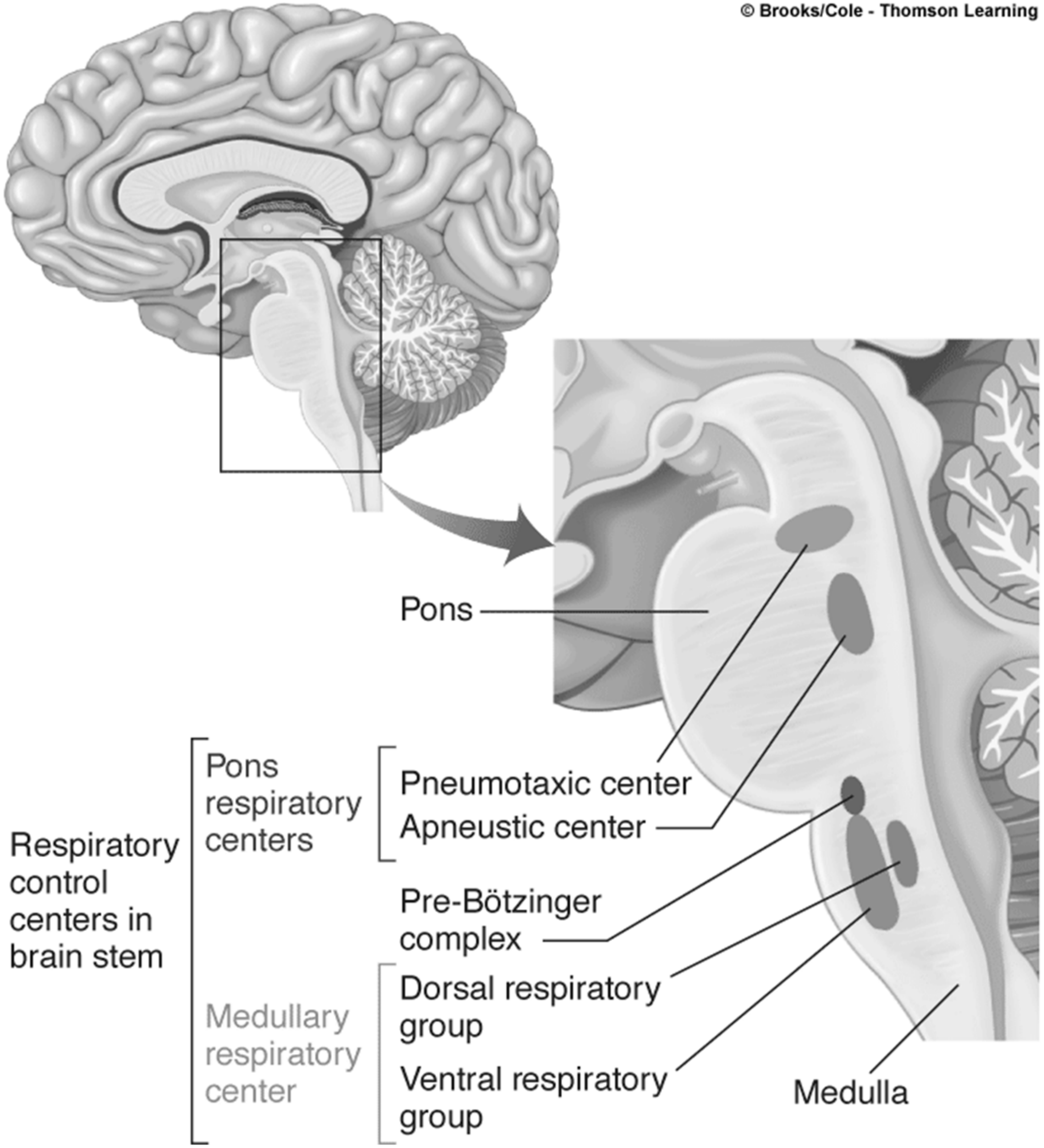
- Lung receptors (continue)
  - ✓ Slowly adapting receptor (pulmonary stretch R.)
    - ➢ Located at airway smooth m
    - ➢ Stimulated by lung inflation
    - ➢ Hering-Breuer inflation Reflex:
      - ↑ lung vol. → ↓ inspiration activity
      - Distention of lung → activate pul. stretch R. → vagus n. → brain →inhibition of insp. activity



Receptors

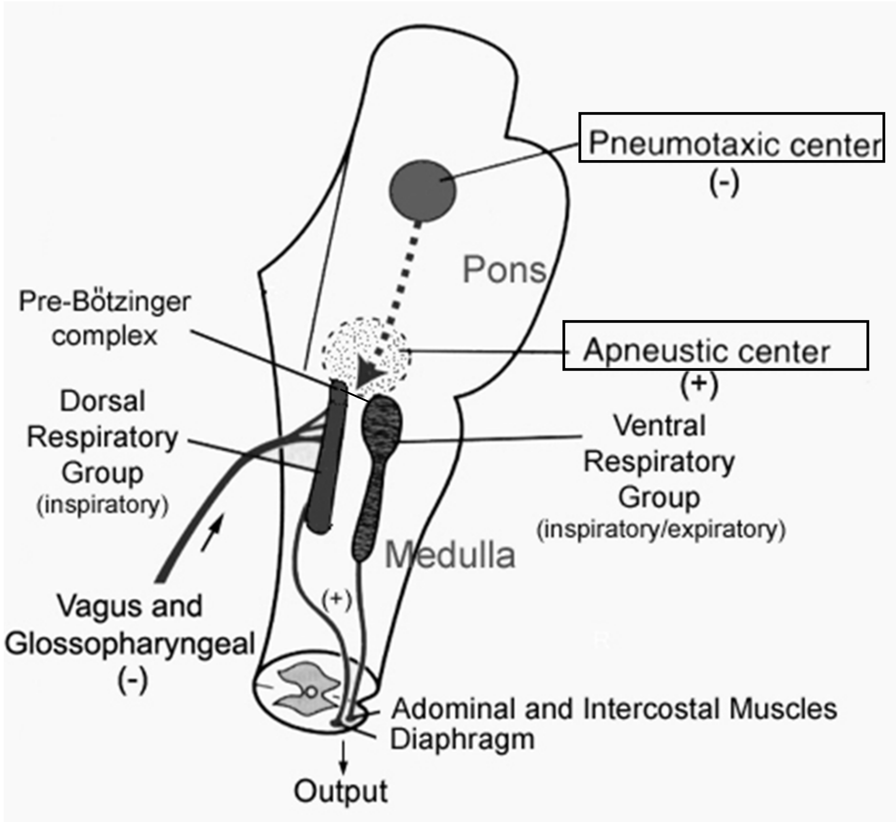
- Lung receptors (continue)
  - ✓ J receptor
    - ➢ Located in the alveolar wall close to capillaries – “juxta-capillary receptor”
    - ➢ Innervated by non-myelinated fibers
    - ➢ Stimulated by pulmonary edema; congestion
    - ➢ Effect: apnea; rapid shallow breathing (tachypnea)
- Nociceptors (pain)
  - ✓ Found in every tissue
  - ✓ Effect: ↑ breathing
- Skeletal m R: thoracic stretch R.
  - ✓ At intercostals m.
  - ✓ Activated by m. elongation

Central Controller in Brain Stem



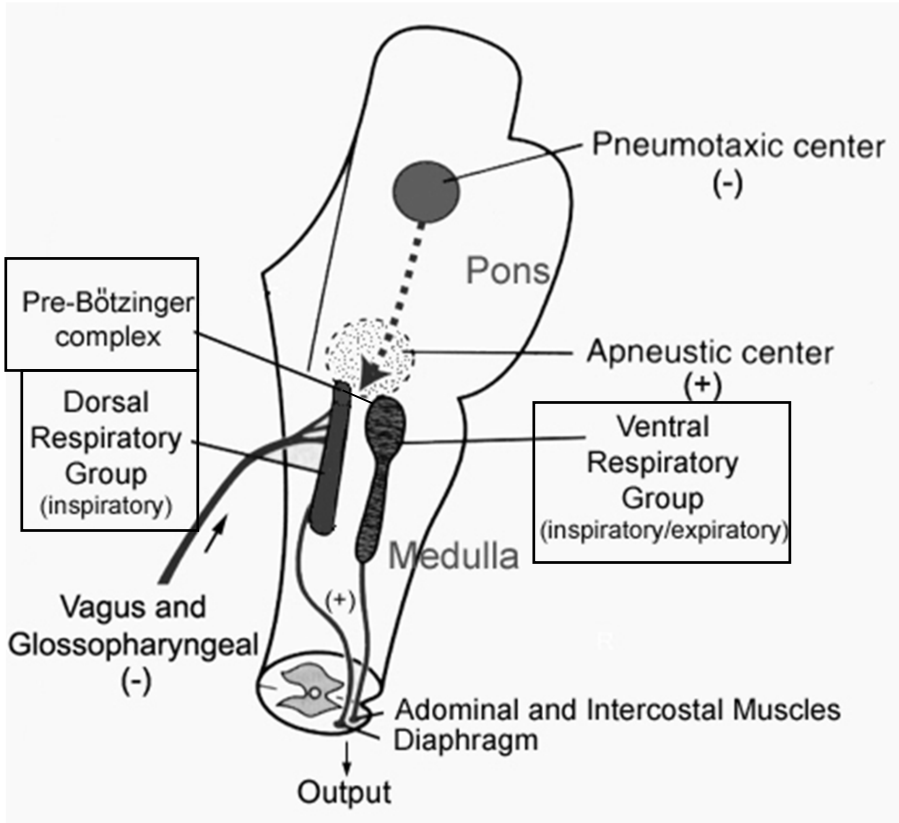
你覺得吸氣比較重要
還是呼氣比較重要?

Central Controller



- Pons:
  - ✓ Pneumotaxic center
    - ➢ fine tune respiratory rate and rhythm
    - ➢ switch off of the inspiratory ramp, thus controlling the duration of the filling phase of the lung cycle
  - ✓ Apneustic center
    - ➢ located in the lower part of the pons
    - ➢ stimulates/prolongs inspiration

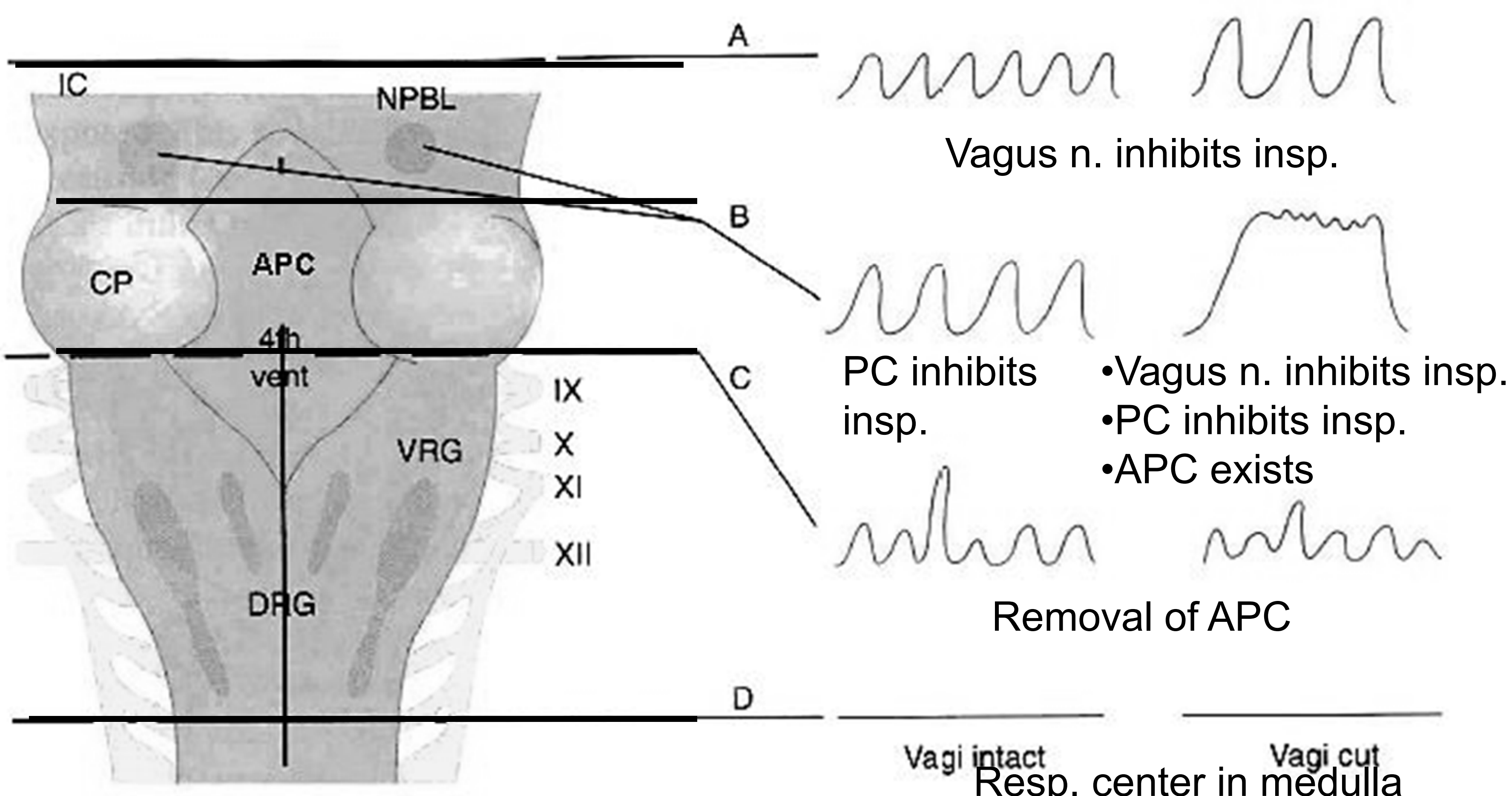
Central Controller



- Medulla
  - ✓ Dorsal medullary resp. group
    - ➢ generate basic rhythm of respiration
    - ➢ causes inspiration
  - ✓ Ventral medullary resp. group
    - ➢ cause either expiration or inspiration
  - ✓ Pre-Botzinger complex:
    - ➢ ventral side of medulla
    - ➢ involve in oscillatory (pacemaker) rhythm

Respiratory Neurons in the Brain Stem

NPBL: nucleus parabrachialis (pneumotaxic center); APC: Apneustic center
VRG: ventral respiratory group; DRG: dorsal respiratory group



正常情況下, 什麼時候呼吸的型態會改變?

Central Controller

- The resp. sys. is absolutely dependent on an external neural drive
- Reflex alters respiratory movements
- For example:
  - Sneezing: short inspiration, forced expirations with glottis open
  - Swallowing: inhibition of respiration
  - Coughing: short inspiration → series of forced expirations with glottis closed (pressure created in airway) → glottis opens suddenly → blast of air carries out irritant material

Central Controller

- Cortical override: voluntary alterations in breathing on a short term basis
- For example:
  - ✓ Diving: hold breath
  - ✓ Speech & singing: interruptions of expiration
  - ✓ Laughter & weeping: deep inspiration then short spasmodic expiration
  - ✓ Sighing: prolong expiration
  - ✓ Yawning: deep inspiration with mouth open
  - ✓ Fear & excitement: rapid breathing

Effectors

- Dorsal & ventral resp. group cross the midline and descend in ventrolateral column of cord
- Inspiratory m: diaphragm, external intercostal m.
- Expiratory m: passive process
  - ✓ forced expiration: internal intercostal m.,
    abdominal m.

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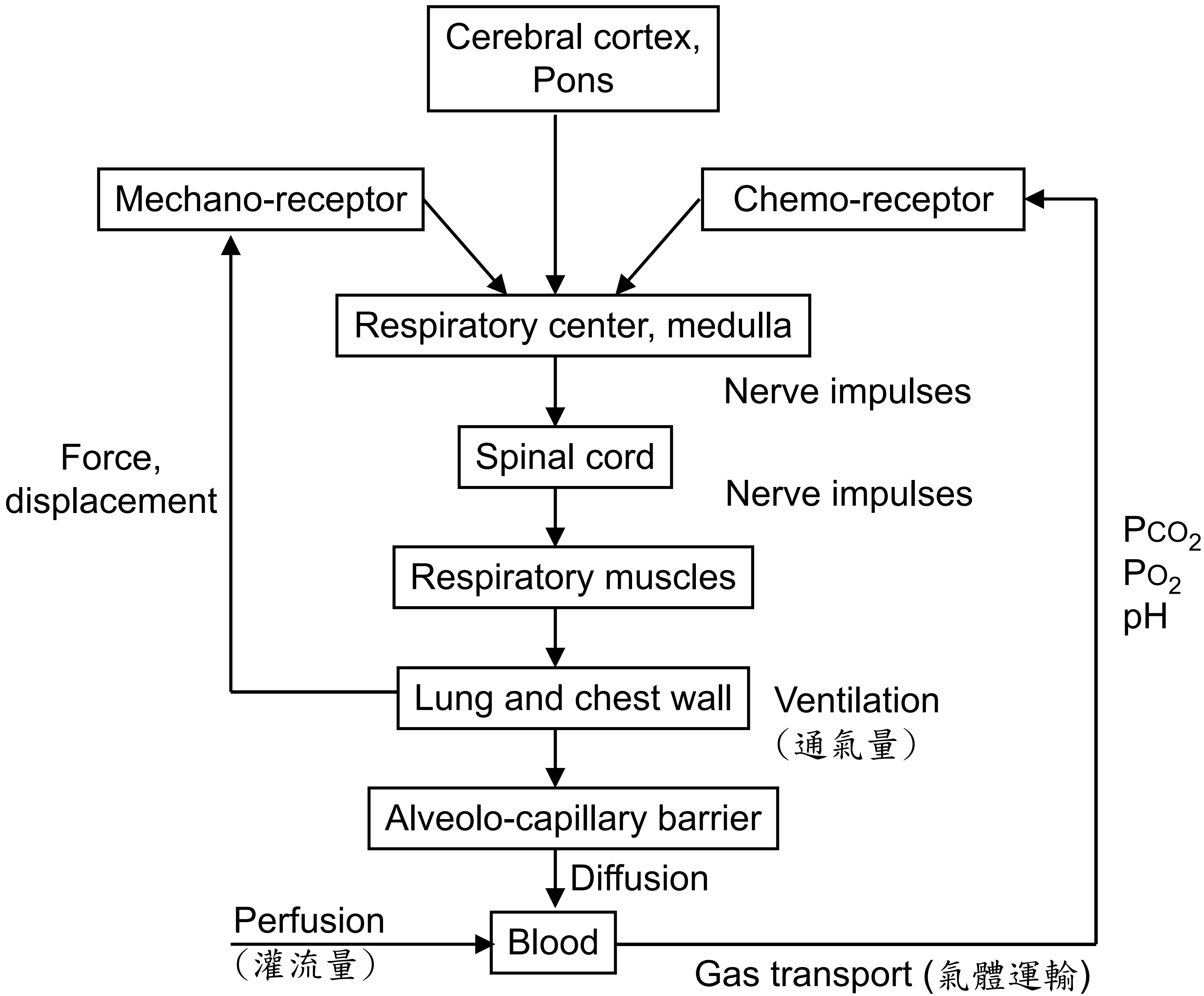
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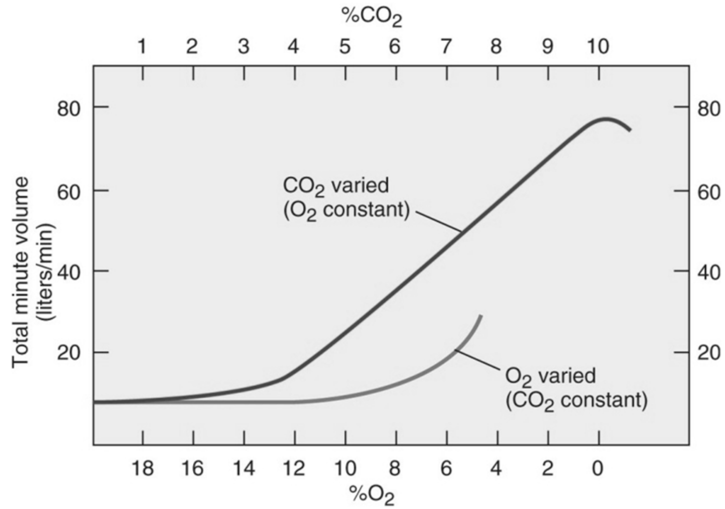
(通氣量)
Alveolo-capillary barrier
Diffusion
Perfusion
(灌流量)
Blood
Gas transport (氣體運輸)

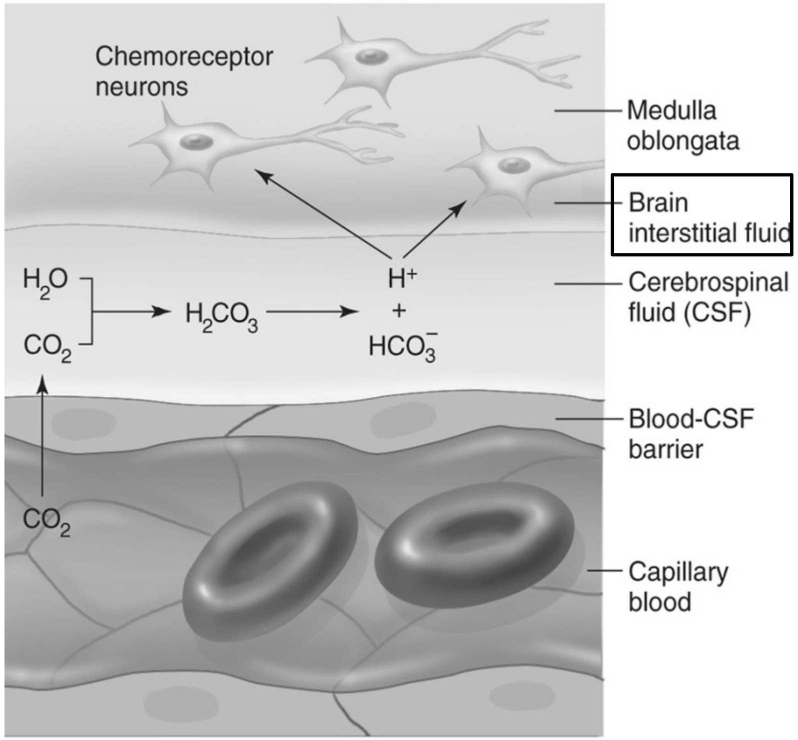
你覺得吸氧氣比較重要
還是排二氧化碳比較重要?

Chemical Control of Resp.

- Two sets of chemoreceptors:
  - ✓ Central chemoreceptors: Responsive to arterial Pco_2 by way of $[H^+]$ in extracellular fluid
  - ✓ Peripheral chemoreceptors: Responsive to arterial Po_2, Pco_2, and $[H^+]$
- The most important single driver of ventilation is Pco_2 acting on the central chemoreceptors by altering extracellular fluid $[H^+]$

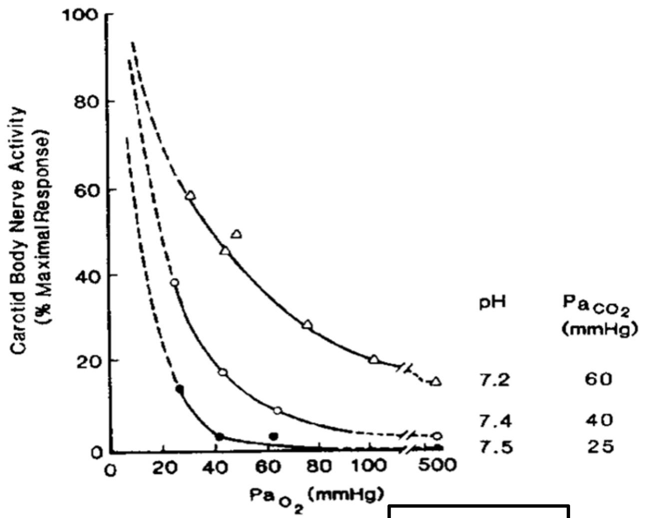


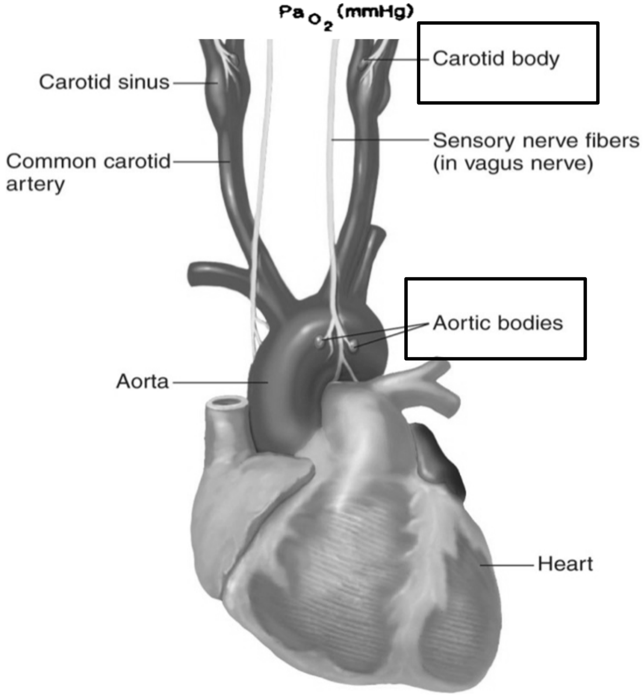
Central Chemoreceptor



- Located in ventrolateral surface of medulla, exposed to extracellular fluid
- Respond to Pa_{CO2}↑, pH↓ in extracellular fluid (not in blood, due to <u>b</u>lood <u>b</u>rain <u>b</u>arrier) → ↑ventilation
  - ✓ CO_2 diffuse across BBB easier
- Do not respond to Pa_{O2}↓

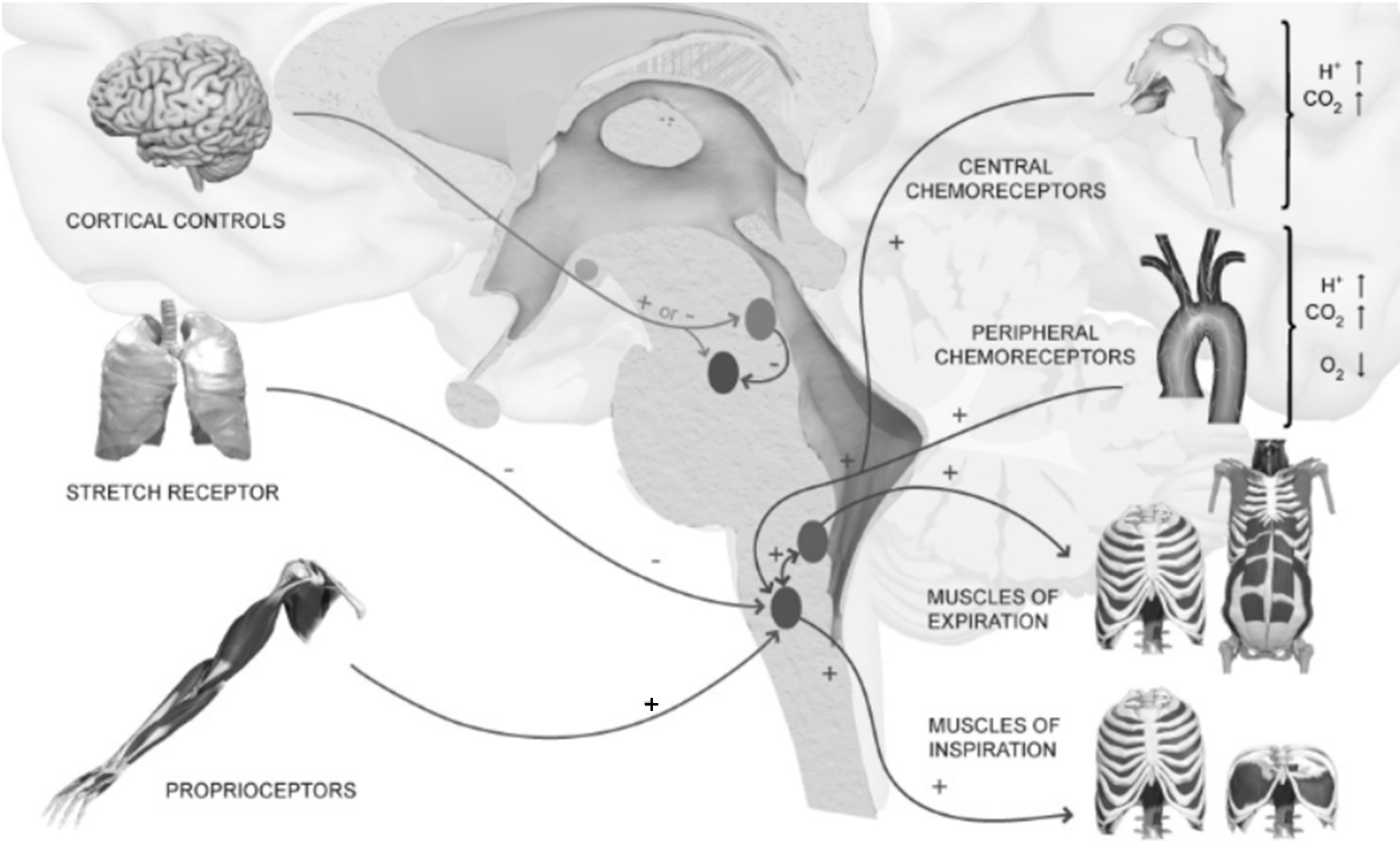
Peripheral Chemoreceptor





- Glomus cells in carotid body & aortic body (Respond to Pa_{O2}↓, Pa_{CO2}↑, pH↓
  → ↑V_T & ↑ freq.
- Neural impulses from the carotid body increase as Pa_{O2}↓
  - ✓ potentiated by acidosis and hypercapnia
- Peripheral chemoreceptor is the ONLY way to sense low P_{O2}

Regulation of breathing in response to changes in blood P_{CO2}, P_{O2}, and pH (H^+) via negative feedback control



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- Examples: exercise and high altitude adaptation

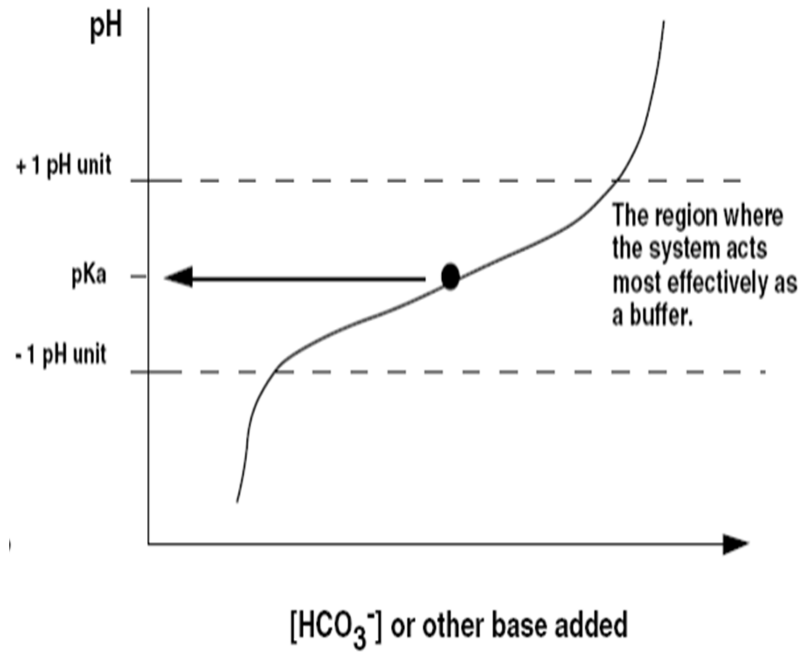
Acid-base Balance

- Blood pH ~ 7.4 +/- 0.05
  - ✓ Acidosis (酸中毒): too much acid in blood, pH ↓
  - ✓ Alkalosis (鹼中毒): too much base in blood, pH ↑
- Categorized by primary cause:
  - ✓ Respiratory: lung; Pco_2 changes
  - ✓ Metabolic: kidney, liver; $[HCO_3^-]$ changes
- Three ways of controlling blood pH:
  - ✓ Buffer systems: bicarbonate, phosphate and Hb
  - ✓ Release of CO_2 from the lung (fast)
  - ✓ Excretion of acids or bases from the kidney (slow)

Effectiveness of a Buffer System

- pKa
  - ✓ Gives the pH where a buffer is most effective
  - ✓ Phosphate (pKa = 7.2), Hb (imidazole group of histidine, pKa=6.8), bicarbonate (pKa = 6.1)
- Amount (concentration) of the buffer
  - ✓ Bicarbonate & Hb

* Bicarbonate is the most important buffer in the body



Bicarbonate

$$CO_2 + H_2O \leftrightarrow H_2CO_3 \rightarrow H^+ + HCO_3^-$$

$$pH = pKa + \log \frac{[\text{conjugate base}]}{[\text{acid}]}$$

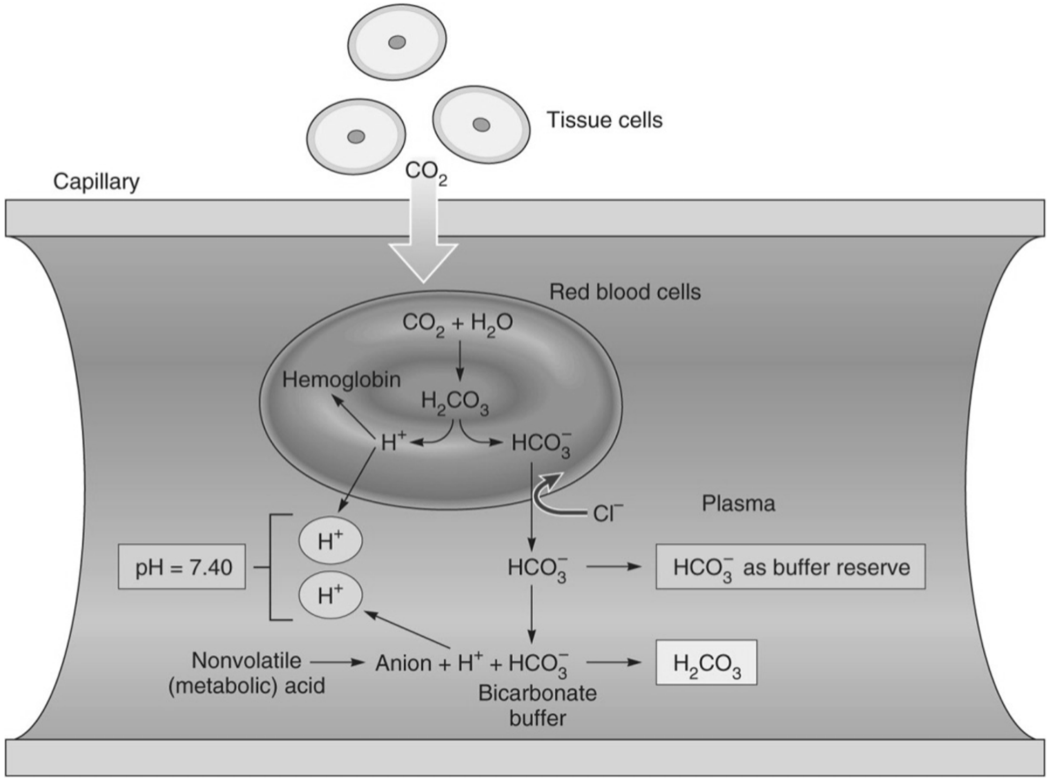
$$pH = pKa + \log \frac{[\text{bicarbonate}]}{[\text{acid}]}$$

$$pH = 6.1 + \log \frac{[HCO_3^-]}{\alpha_{CO2} \times P_{CO2}}$$

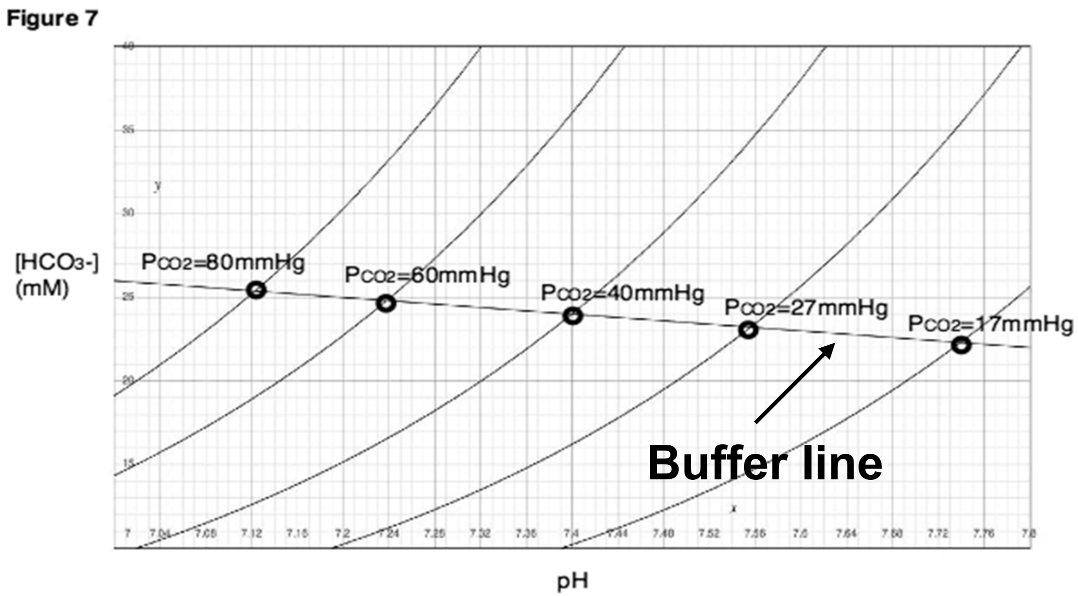
$[H_2CO_3] = 0.03 \times Pco_2$ (Henry's law)

The Effect of Bicarbonate on Blood pH

- Released into the plasma from RBC buffers the H^+ produced by the ionization of metabolic acids (lactic acid, fatty acids, ketone bodies, etc.)



Davenport Diagram



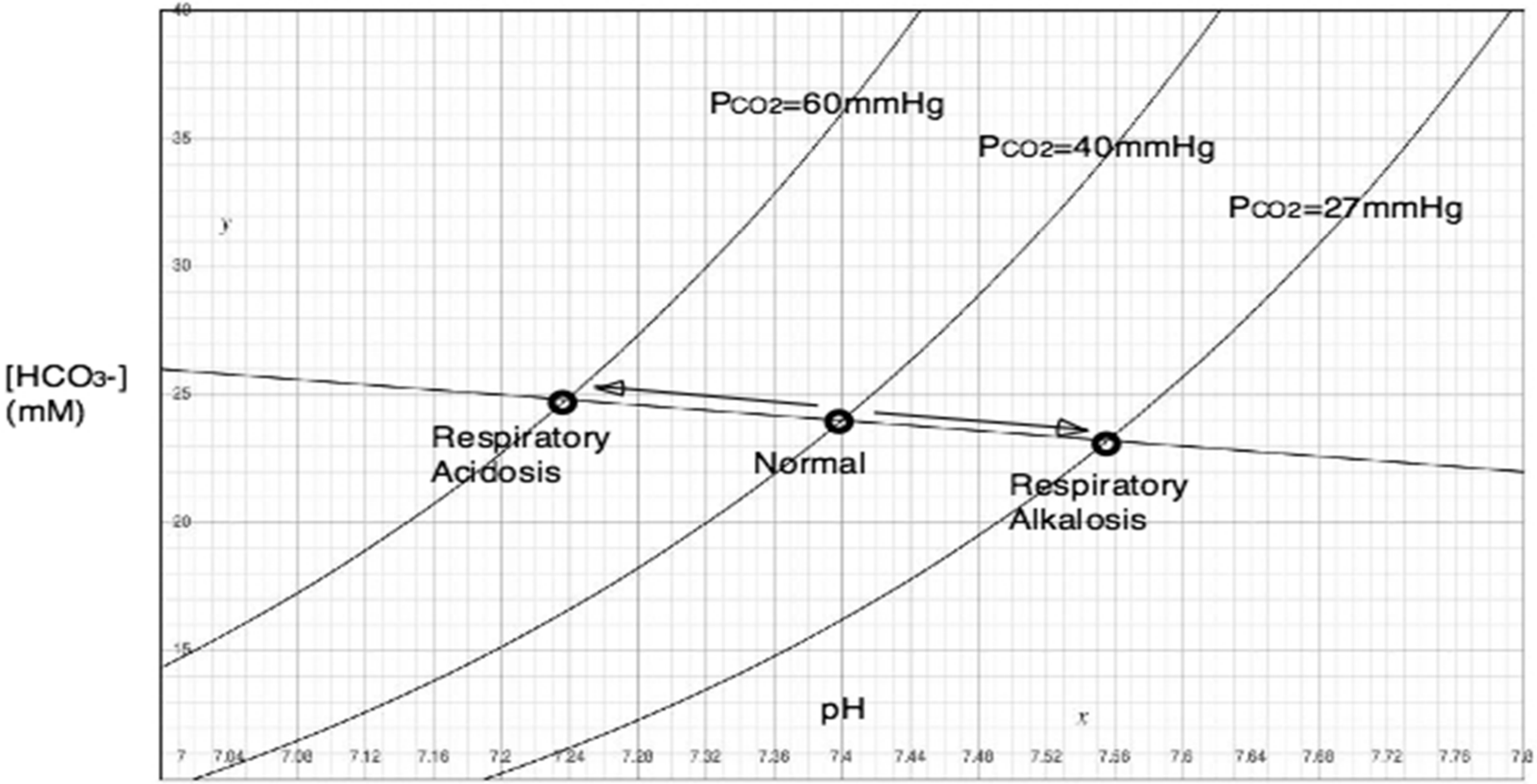
$$pH = 6.1 + \log \frac{[HCO_3^-]}{\alpha_{CO_2} \times P_{CO_2}}$$

arterial blood: P_{CO2} = 40 mmHg

- pH 7.4, αco_2 = 0.03
- $[HCO_3^-]$ = 24 mM

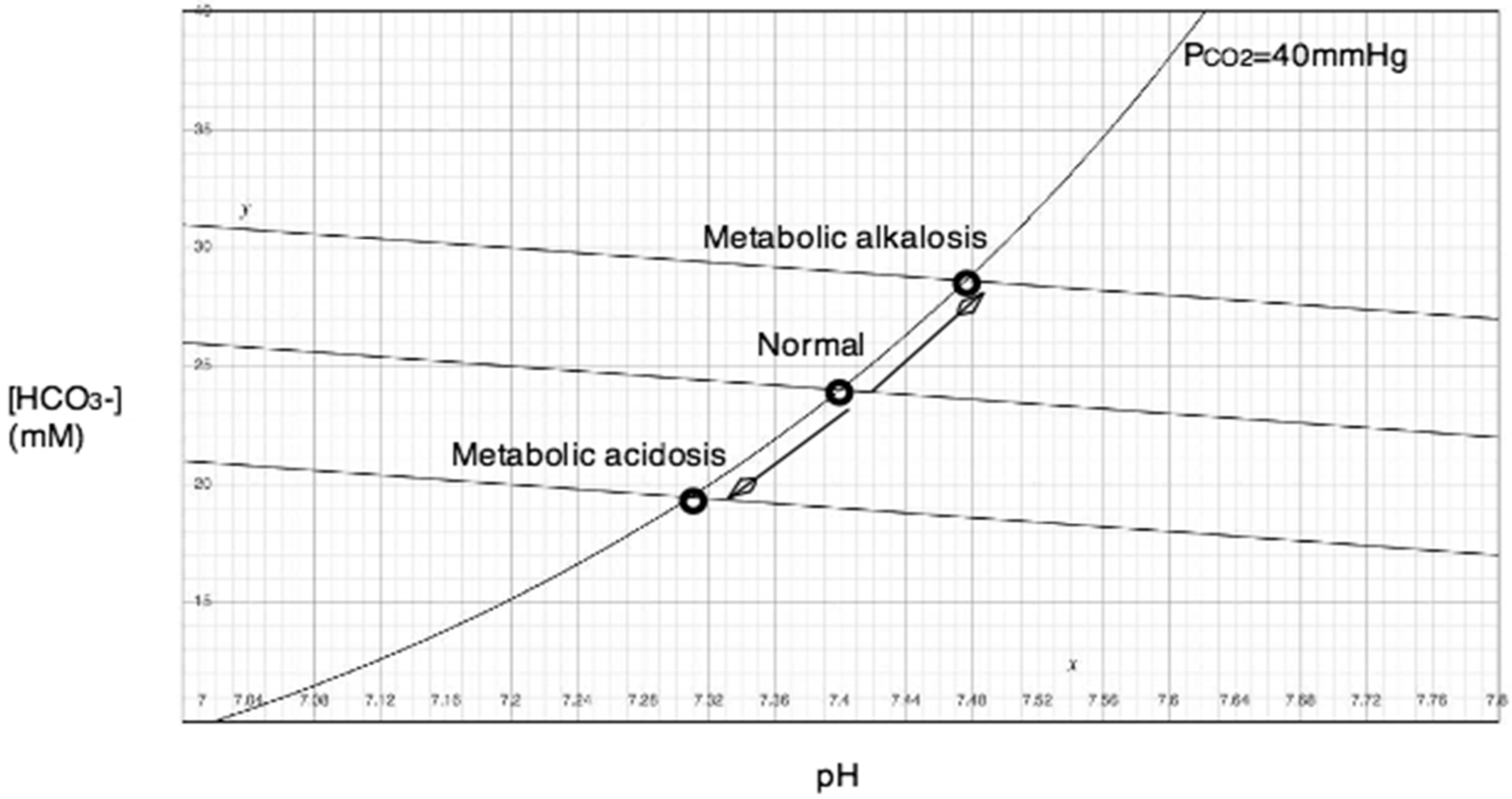
Respiratory Disturbances

Figure 11

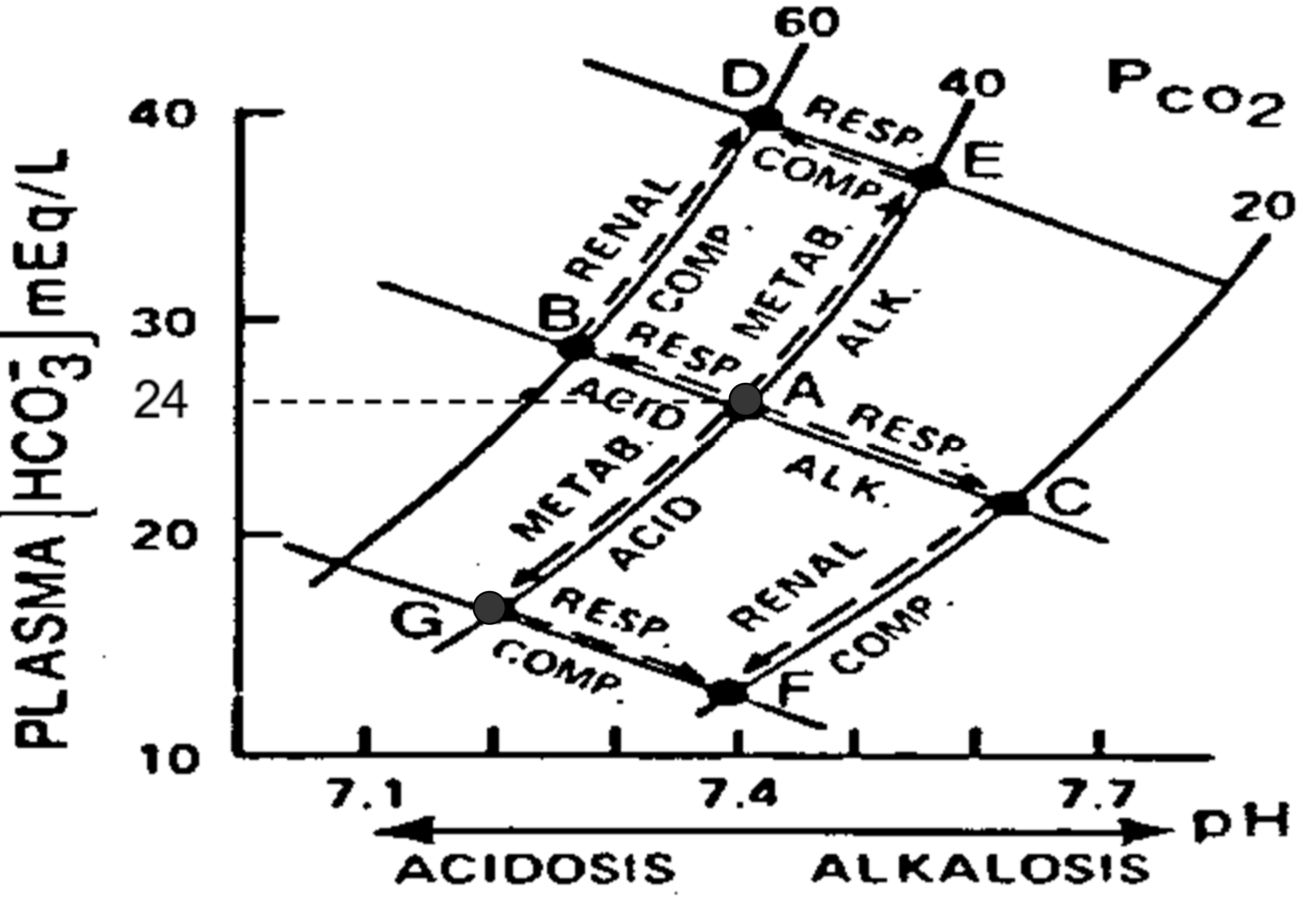


Metabolic Disturbances

Figure 12



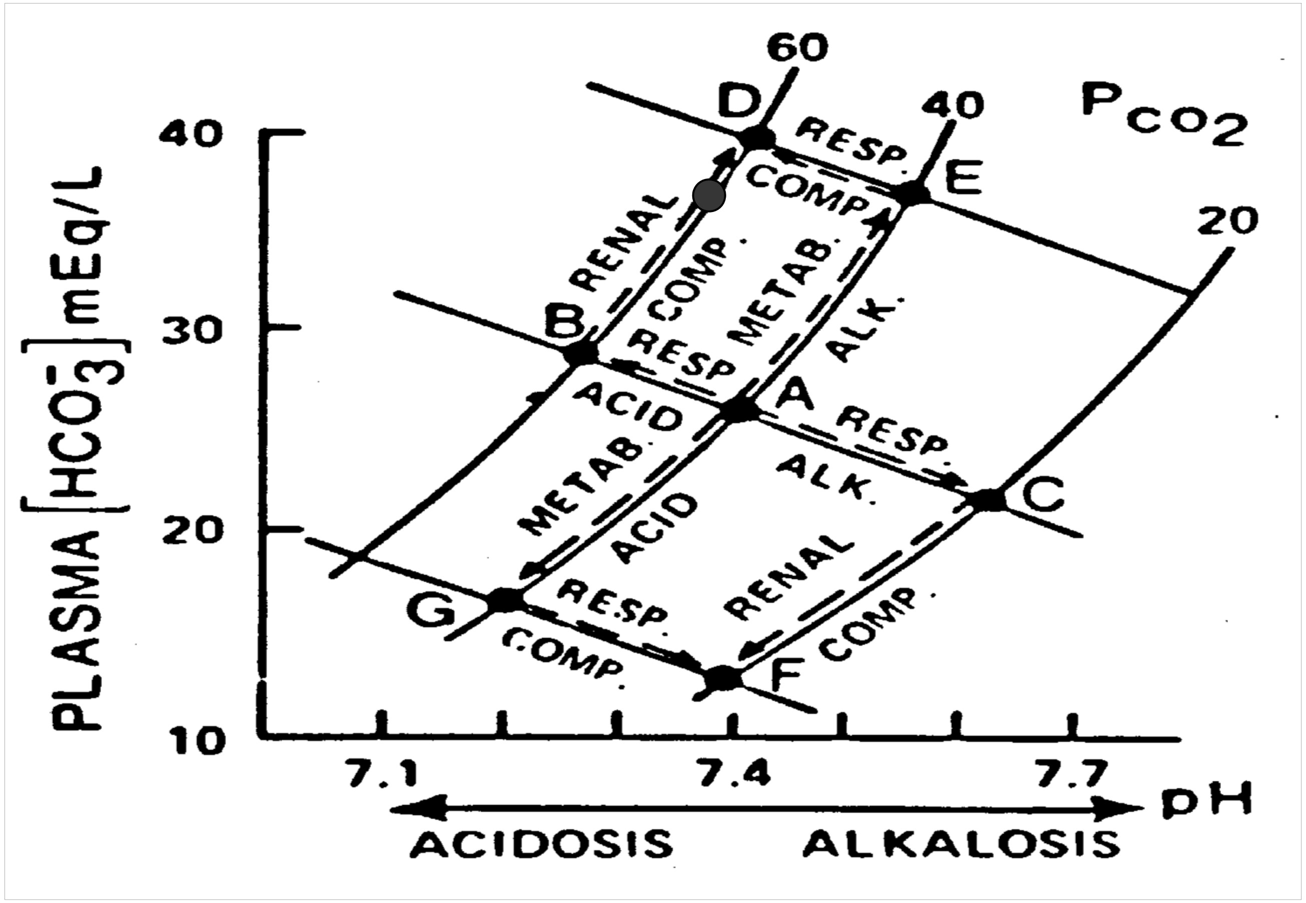
Compensatory Responses



E.g., diabetic patient: ketoacidosis, hyperventilation, pH=7.4

Metabolic acidosis with respiratory alkalosis

Compensatory Responses



$[HCO_3^-]$ = 37 mM; Pco_2= 60 mmHg; pH= 7.4

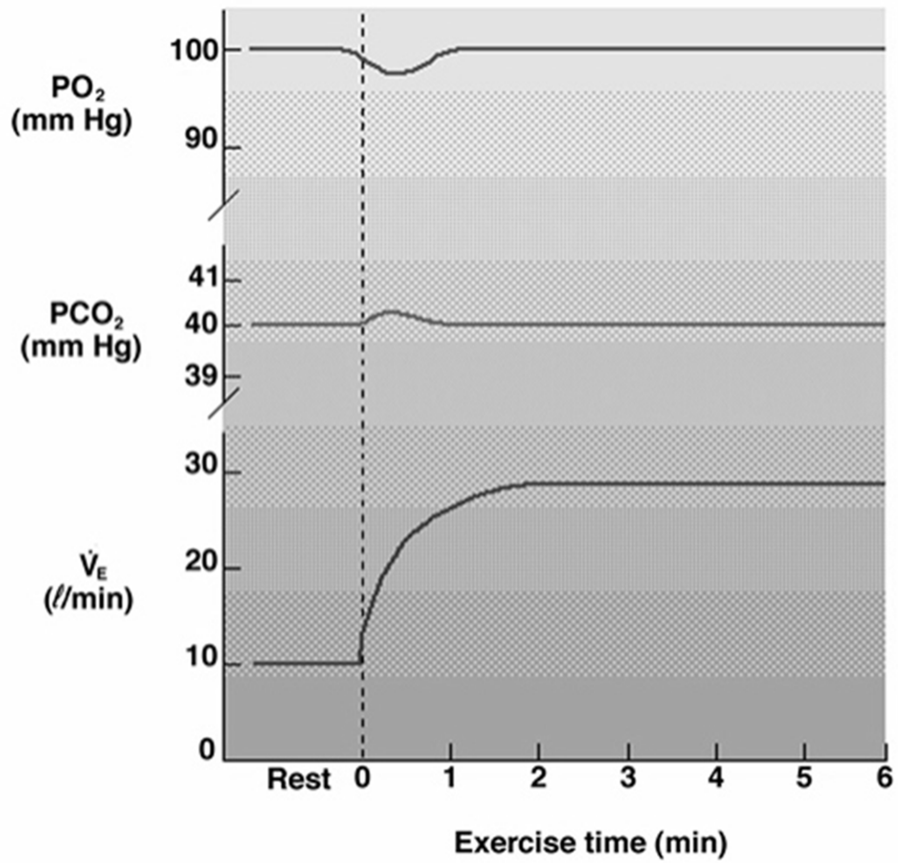
Metabolic alkalosis with respiratory acidosis

Outline

- Background
- Structure and function
- Ventilation
- Perfusion and ventilation/perfusion ratio
- Static/Dynamic respiratory mechanics
- Diffusion and gas transport
- Neural control of respiration
- Chemical control of respiration
- Acid-base balance
- Examples: exercise and high altitude adaptation

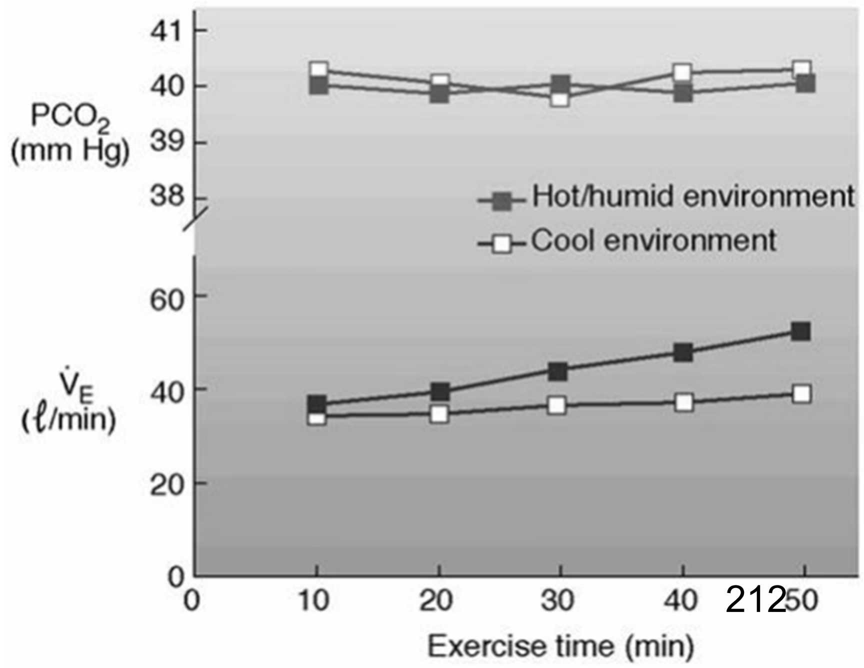
Rest-to-Work Transitions

- Initially, ventilation increases rapidly
  - ✓ Then, a slower rise toward steady-state
- P_{O2} and P_{CO2} are maintained

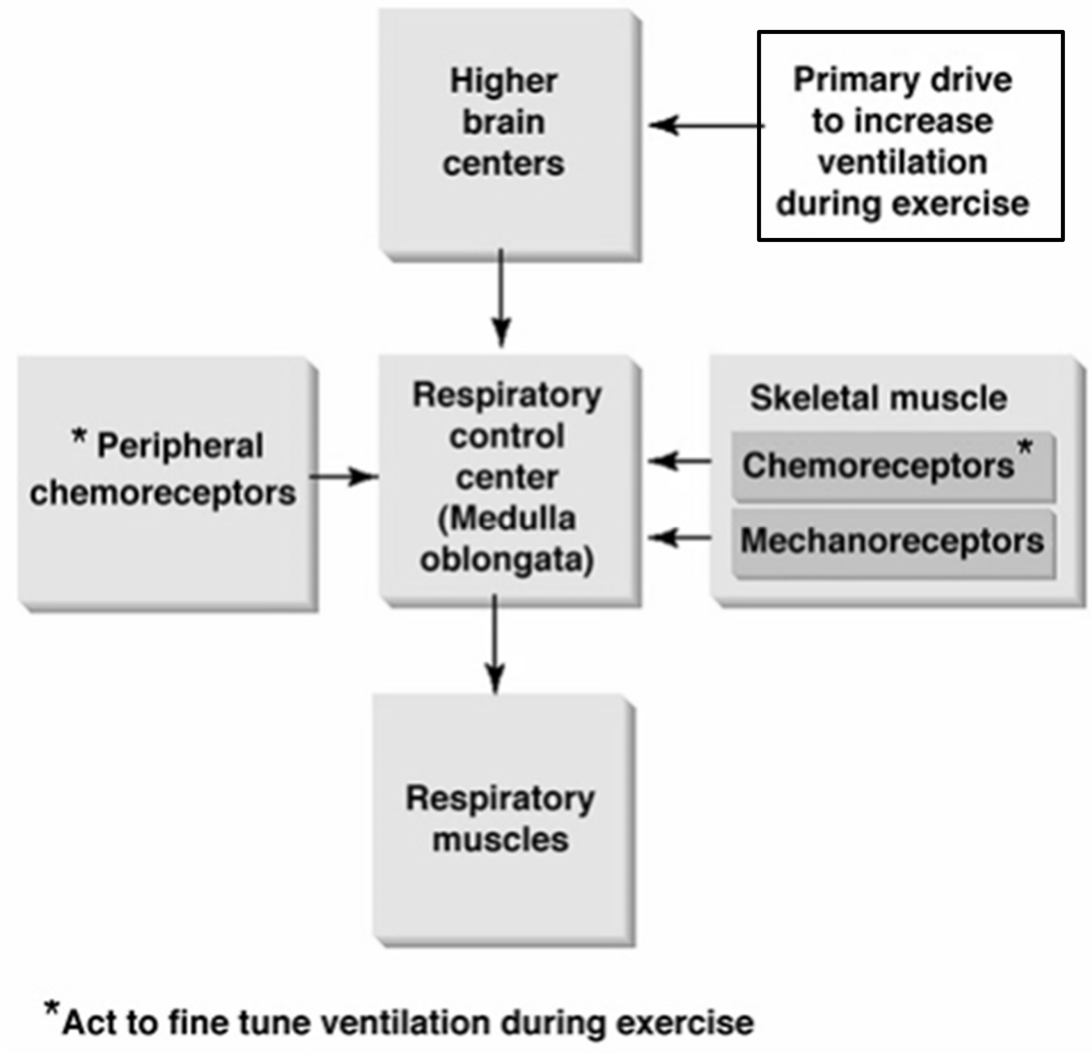


Sub-maximal Exercise

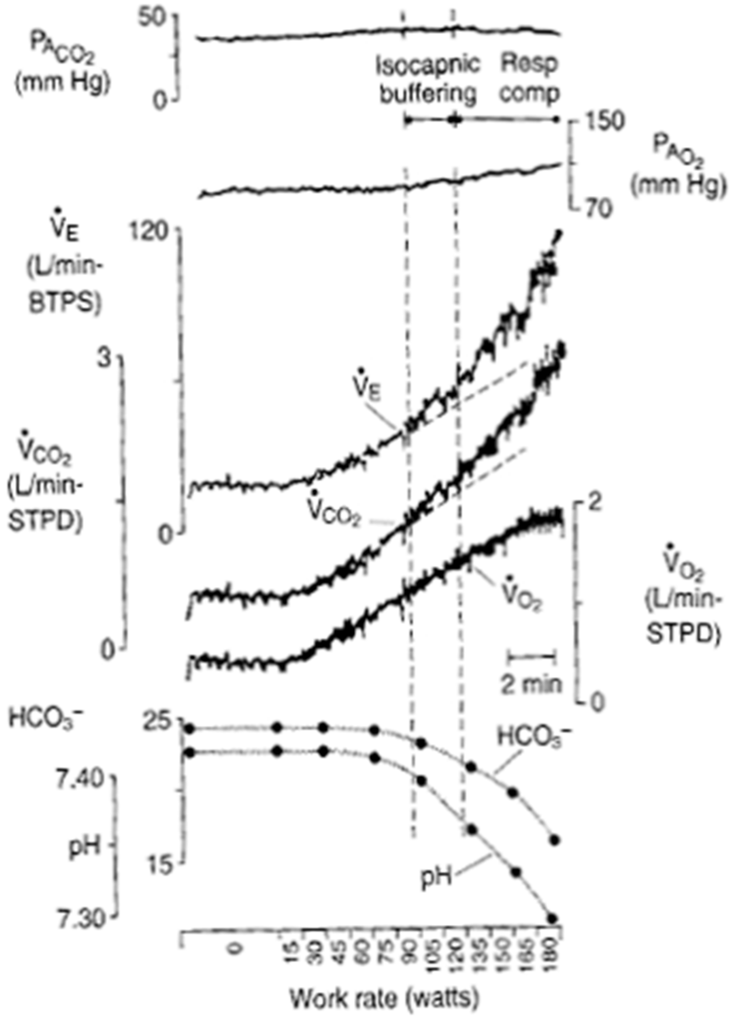
- During prolonged submaximal exercise:
  - ✓ Ventilation tends to drift upward
  - ✓ Little change in P_{CO2}
  - ✓ Higher ventilation not due to increased P_{CO2}
  - ✓ Linear increase due to:
    - ➢ Central command
    - ➢ Neural feedback



Ventilatory Control During Submaximal Exercise

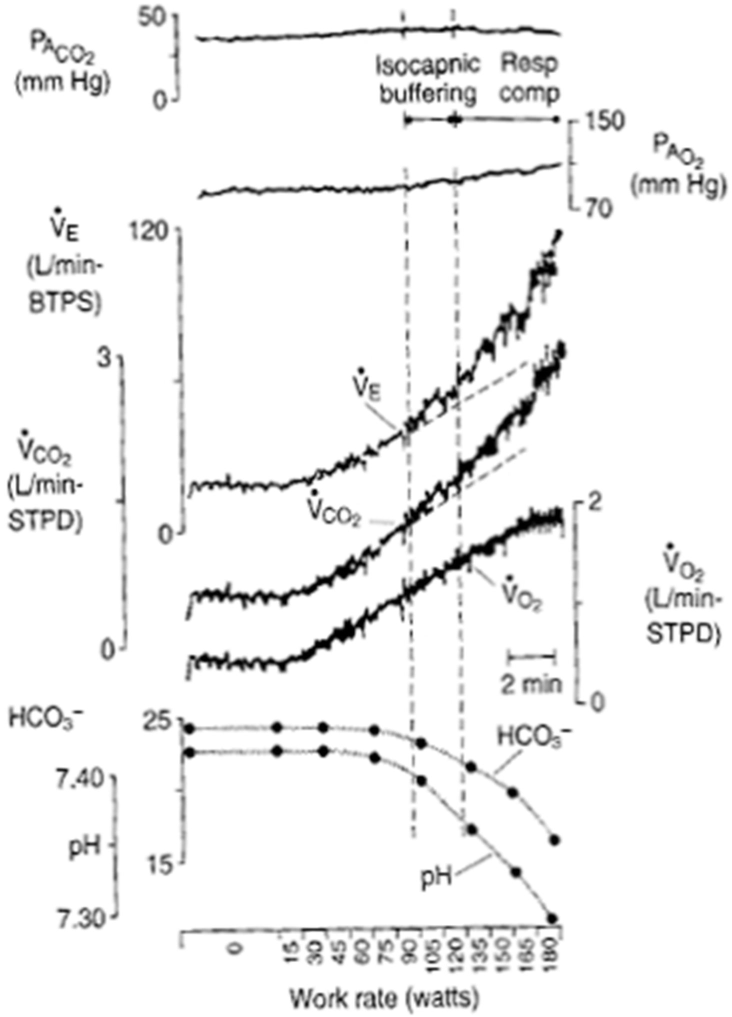


High Intensity Exercise



- Little change in alveolar $P_{ACO2,}$ P_{AO2}
- $\dot{V}_E$ (ventilation) linearly increase with exercise intensity until 50-75% $\dot{V}O_{2max}$
- $\dot{V}O_{2max:}$ maximal oxygen uptake; also called aerobic capacity
  - ✓ Indicate exercise intensity
  - ✓ Determined by a person's age, sex, size, and athletic training

High Intensity Exercise



- Ventilatory threshold (T_{vent}) ~ anaerobic threshold ~ lactate threshold
  - ✓ $\dot{V}_E$ and $\dot{V}_{CO2}$ exponentially increase beyond this point
  - ✓ Exponential increase due to: decreasing HCO_3^-, increasing blood H^+ (decreasing pH)

Oxygen Debt

- When a person exercises, oxygen is withdrawn from reserves in hemoglobin and myoglobin to generate energy (ATP)
  - ✓ To create power stroke in muscle contraction and pump calcium back into SR at rest
- After exercise
  - ✓ To metabolize lactic acid in gluconeogenesis

- Breathing rate continues to be elevated after exercise to repay this debt

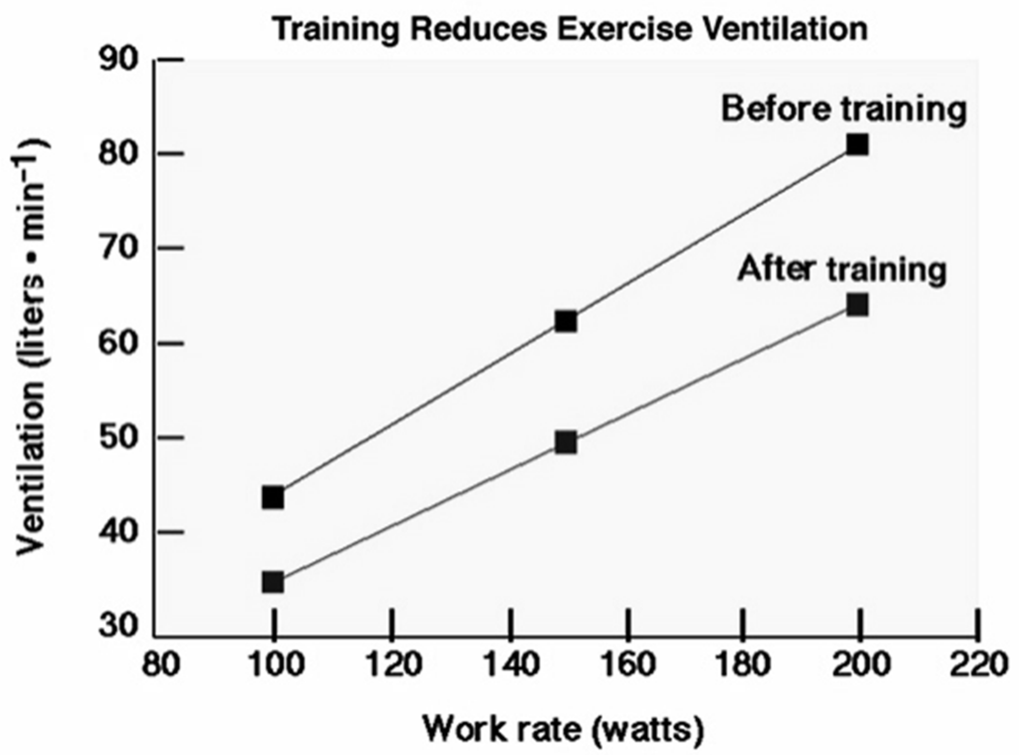
呼吸系統是運動的限制因子嗎?

Do the Lungs Limit Exercise Performance?

- Low-to-moderate intensity exercise
  - ✓ Pulmonary system not seen as a limitation
- Maximal exercise
  - ✓ Not thought to be a limitation in healthy individuals at sea level
  - ✓ May be limiting in elite endurance athletes
  - ✓ Respiratory muscle fatigue may occur during high intensity exercise

Effect of Training on Ventilation

- Ventilation is lower at same work rate following training
  - ✓ May be due to lower blood lactic acid levels
  - ✓ Results in less feedback to stimulate breathing



How to Increase Resp. Function During Exercise?

- Deeper, faster breathing to match oxygen utilization and CO_2 production → hyperpnea (ventilation ↑; Pco_2 ↔)
  - Expiration muscle contraction
  - Pursed lip breathing (dynamic airway compression)
  - Body heat is expelled during exhalation
- Excitation of sympathetic nerve → bronchodilation (resistance ↓)
- Increase blood flow → O_2 diffusion ↑ (perfusion-limited gas), perfusion ↑, transport time ↓
- Decrease O_2 affinity of hemoglobin → unload O_2 to tissue

How to Increase Resp. Function During Exercise?

- Neurogenic and humoral mechanisms control this
  - Neurogenic mechanisms
    - Cerebral cortex stimulates respiration via respiratory centers
    - Sensory n. activity from exercising m. stimulates respiration via spinal reflexes or brain stem resp. centers
  - Humoral mechanisms (oxygen debt)
    - Rapid and deep breathing continues after exercise due to humoral factors
      - P_{CO2} and pH differences at sensors

Effect of High Altitude on Resp. Function

- Adjustments must be made to compensate for lower atmospheric P_{O2}
  - ✓ Immediate: Increased in ventilation
  - ✓ Days: Decreased hemoglobin affinity for oxygen
  - ✓ Days to weeks: Increased total hemoglobin concentration

Immediate: Increased in Ventilation

- Hypoxic ventilatory response: decreases in P_{O2} stimulate the carotid bodies to increase ventilation
  - ✓ Hyperventilation lowers P_{CO2}, causing respiratory alkalosis
  - → Hb affinity to O_2 increase (immediate effect)
  - ✓ Kidneys increase urinary excretion of bicarbonate to compensate
  - ✓ Lung hypoxia → vasoconstriction → pulmonary hypertension

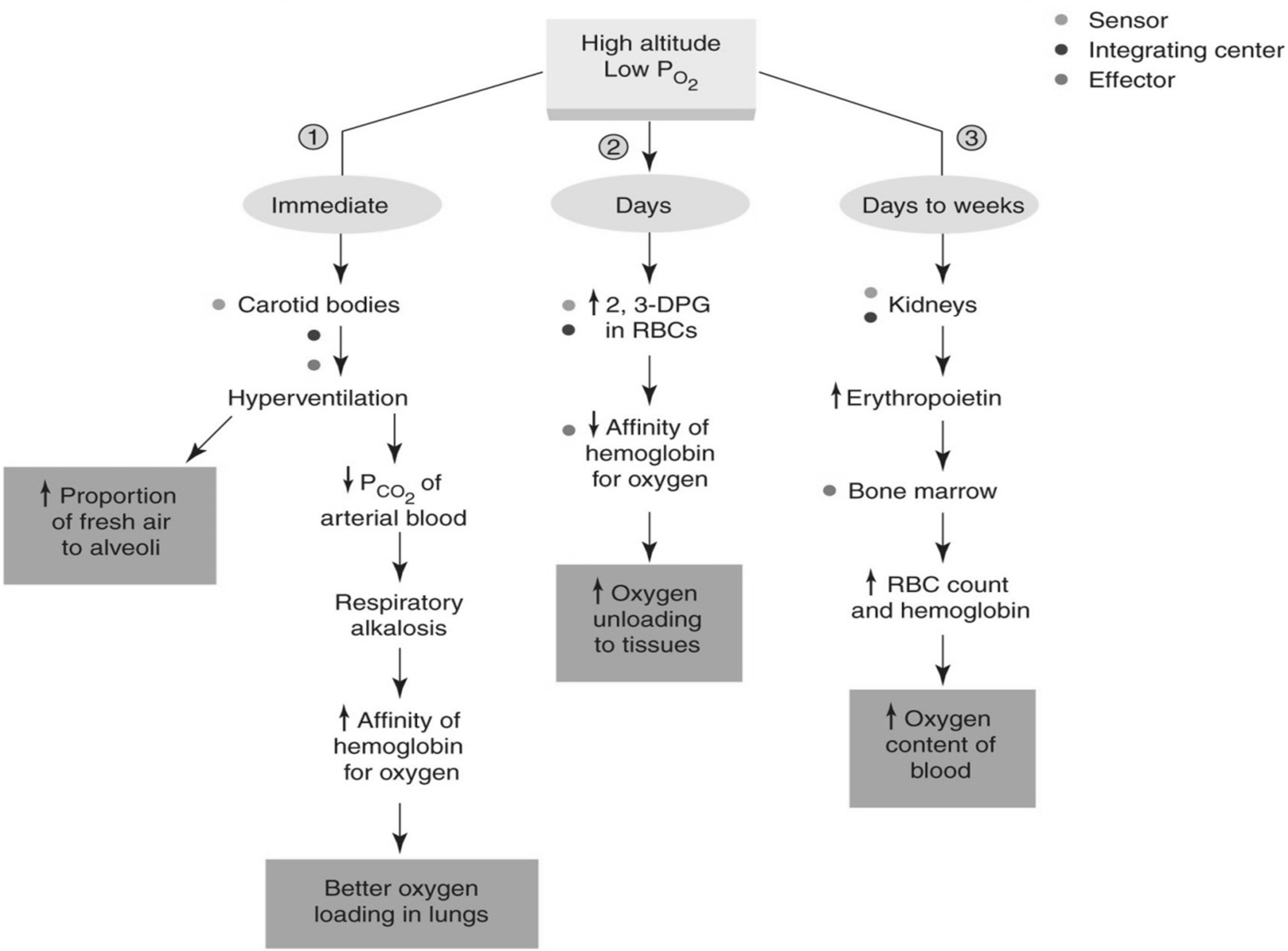
Days: Decreased Affinity of Hemoglobin for Oxygen

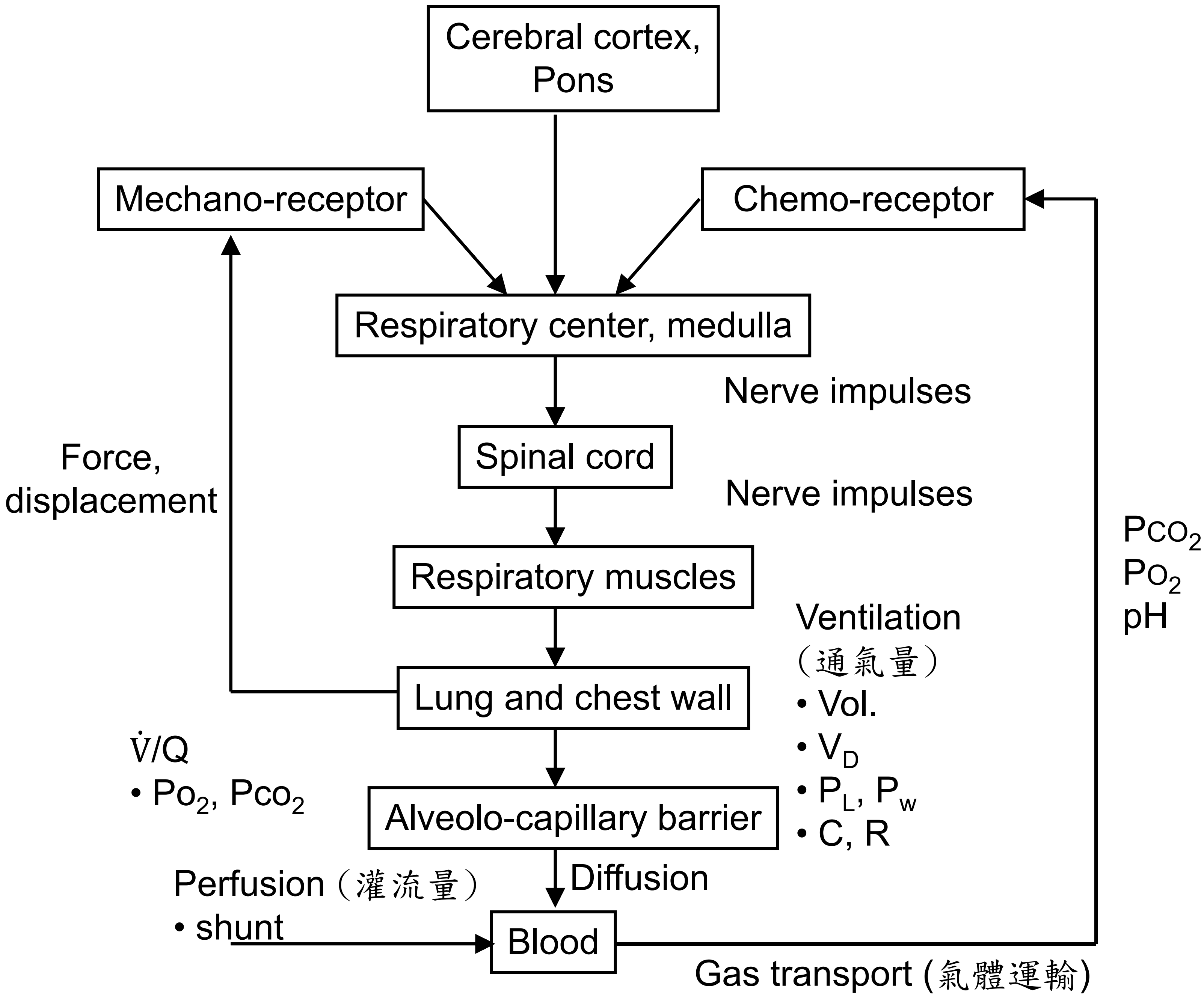
- Oxygen affinity decreases, so a higher proportion of oxygen is unloaded
  - ✓ Occurs due to increased production of 2,3-DPG
  - ✓ At extreme high altitudes, effects of respiratory alkalosis will override this, and Hb affinity for oxygen will increase

Days to weeks: Increased Hemoglobin Production

- Kidney cells sense decreased P_{O2} and produce erythropoietin
  - ✓ This stimulates bone marrow to produce more hemoglobin and RBCs
  - ✓ Increased RBCs can lead to polycythemia, which can increase O_2 diffusion capacity

Respiratory Adaptations to High Altitude





Cerebral cortex, Pons
Mechano-receptor
Chemo-receptor
Respiratory center, medulla
Nerve impulses
Spinal cord
Nerve impulses
Force, displacement
Respiratory muscles
PCO_2
PO_2
pH
Ventilation (通氣量)
• Vol.
• V_D
• P_L, P_w
• C, R
Lung and chest wall
$\dot{V}/Q$
• Po_2, Pco_2
Alveolo-capillary barrier
Perfusion (灌流量)
• shunt
Diffusion
Blood
Gas transport (氣體運輸)

The End!

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- JB West, Respiratory Physiology: the essentials