LUNG MECHANICS

Airways Resistance

- **Measurement at 30 l/min**
  a. awake ~ 0.6-3.2 cmH\textsubscript{2}O/l/s
  b. paralysed ~ 6.0 cmH\textsubscript{2}O/l/s
  c. partially paralysed + ETT ~ 10-15 cmH\textsubscript{2}O/l/s (AB says 5-10 cmH\textsubscript{2}O/l/s)
  d. PEFR males ~ 450-700 l/min females ~ 300-500 l/min
  e. FEV\textsubscript{1} ~ 50-70 ml/kg ≥ 70% of FVC

- **Factors**
  a. airway narrowing - oedema, congestion - inflammation, FB, etc.
  b. lung volume - expiration > inspiration - closing volume
  c. posture - supine FRC ≤ CC
  d. neural factors
    i. constriction - smoke, dust, chemicals - hypoxia, hypercarbia, hypothermia - pulmonary emboli - ↑ PNS activity
    ii. dilatation - systemic hypertension - inspiration - ↑ SNS activity
  e. hormonal factors - catechols, histamine, PG’s, leukotrienes
  f. drugs
    i. constriction - histamine, methacholine - alveolar hypocarbia - ACh-esterase inhibitors - anaphylactoid reactions
    ii. dilatation - catechols (\(\beta_2\)-agonists) - PDE inhibitors, aminophylline - anticholinergics - steroids - volatile anaesthetic agents - nitric oxide
- **Anatomical Site**
  
  a. nasal passages ~ 50%
  b. larynx ~ 25%
  c. large airways ~ 15%

  **NB:** airways resistance is maximal at *segmental bronchioles*,

  → ≥ 5th generation / ≤ 2mm

- **Lung Compliance**

  **Def’n:** the change in lung volume per unit change in transpulmonary pressure

<table>
<thead>
<tr>
<th>Posture</th>
<th>Static Lung</th>
<th>Respiratory Lung</th>
<th>Dynamic Lung</th>
<th>Respiratory Lung</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upright</td>
<td>200</td>
<td>100</td>
<td>180</td>
<td>100</td>
</tr>
<tr>
<td>Supine</td>
<td>150</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GA &amp; NMB’d</td>
<td>100-150</td>
<td><strong>75</strong></td>
<td>80</td>
<td>55</td>
</tr>
</tbody>
</table>

* all values in ml/cmH₂O

- **Factors Affecting Static Lung Compliance**

  1. ↑ FRC → ↑ C_L
     i. age
     ii. body size
     iii. posture
     • *see below factors affecting FRC*

  2. ↓ lung volume → ↓ C_L
     i. lobar, lung resection
     ii. collapse or consolidation
     iii. diffuse atelectasis

  3. changes in lung *elasticity*
     i. ↑ lung elasticity - emphysema
     ii. ↓ lung elasticity - pulmonary oedema, congestion, fibrosis
Nunn: Lung Compliance

1. lung volume - absolute and relative
2. posture
3. pulmonary blood volume
4. age
5. restriction of chest expansion ? this is chest wall C, not lung
6. recent ventilatory history * monotonous ventilation
7. pulmonary disease

Factors Affecting Dynamic Lung Compliance

1. airways resistance
2. respiratory rate
3. peak flow rate & inspiratory time for ventilated patients
4. autoPEEP

* actually should refer to time constant, \( \tau = R \times C \)
* the concept of dynamic compliance is flawed, as it is resistance & flow rate dependent
* resistance includes in its definition the time frame (cmH\(_2\)O/l/s), compliance does not
* ergo, compliance should be time independent, but dynamic compliance is not

Factors Affecting Chest Wall Compliance

1. muscle tone and phase of respiration
2. diaphragmatic movement
   i. neural input
   ii. muscle performance, fatigue
   iii. abdominal hypertension - pregnancy, ascites, obesity
3. chest wall diseases
   i. spine & costo-vertebral joints
   ii. obesity
   iii. pleural disease, space occupying lesion
   iv. skin & overlying tissues
Factors Affecting FRC

1. body size - FRC $\propto$ height (~ 32-51 ml/inch)
2. sex - females ~ 90% of male FRC (≡ height)
3. age - Nunn $\rightarrow$ no correlation!
   - others have shown small increase
4. diaphragmatic muscle tone
   - originally, FRC believed to represent equilibrium for lung/chest wall system
   - diaphragmatic tone maintains FRC $\sim$ 400 ml above true relaxed state
   $\rightarrow$ ↓ FRC with anaesthesia / ventilation
5. posture $\rightarrow$ ↓ FRC in the supine position $\sim$ 0.5-1.0 l
6. lung disease
   - consolidation, collapse, atelectasis $\rightarrow$ ↓ FRC
   - ↑ blood volume, alveolar oedema $\rightarrow$ ↓ FRC
   - loss of lung ER with emphysema $\rightarrow$ ↑ FRC
   - increased expiratory resistance $\rightarrow$ ↑ FRC
7. chest wall
   - increased abdominal contents $\rightarrow$ ↓ FRC
   - pleural space occupying lesion $\rightarrow$ ↓ FRC
8. alveolar-ambient pressure gradient
   - PEEP increases the FRC
Closing Volume

**Def'n:** lung volume in which closure of dependent airways begins, or more precisely, lung volume in which dependent lung units cease to contribute to expired gas, i.e., the beginning of phase IV of the washout curve to RV

normal values ~ 15-20% of VC, i.e. a part of the VC manoeuvre
~ 10% of the FRC in a young adult
~ 40% of FRC at 40 years of age

this is distinct from closing capacity, which is the difference between the onset of phase IV and zero lung volume = CV + RV, expressed at a % of TLC

• measured by either a bolus or resident gas technique,

1. **bolus technique**
   • originally xenon or argon, usually now helium
   • inspiration from RV to TLC creating differential tracer gas composition
   • apical areas contain most of the gas cf. bases

2. **resident gas technique**
   • also dependent upon a pre-expiration concentration gradient, but
   i. N₂ already present, and
   ii. normally little difference in [N₂] between apex & base at TLC
   • therefore, inspiration of O₂ is used to dilute the already present N₂
   • this results in an apical to base concentration difference of ~ 2x
   • may result in smaller values cf. bolus technique in the presence of asthma or bronchoconstriction, probably due to air trapping (??)

**NB:** → single breath (100% O₂) nitrogen washout

→ 4 phases
I  dead space
II  transitional zone
III alveolar plateau (~ 1.5% rise)
IV  closing volume

• as CV represents a portion of the VC manoeuvre, it is usually expressed as a percentage of such
• expiration must be performed slowly to prevent dynamic airways collapse ~ 0.5 l/sec
• changes in CV may represent small airways disease, or loss of elastic recoil and parenchymal supportive tissue
• loss of elastic recoil results in the gradual increase in CV with age, such that at 65 yrs CC > FRC
• young children similarly have decreased elastic recoil & relatively increased CC’s
• minimal values for CV/CC are seen in late the late second decade
• sensitive marker of early dysfunction, but difficulty defining normal limits

**NB:** closing capacity ~ FRC in the supine position at 6 & 44 years
Factors

- CV is increased by,
  1. age
  2. smoking
  3. lung disease

- tidal volume encroaches upon CV in,
  1. children < 6 years of age
  2. adults progressively over the age of 45
  3. where FRC is decreased
     - obesity
     - pregnancy
     - postoperatively
     - paralysed/ventilated without PEEP
     - ascites
  4. most lung diseases
Pulmonary Dead Space

Def’n: Anatomical: that fraction of the inspired gas volume which, is contained in the conducting airways, is ineffective in arterialising mixed venous blood, and is exhaled unchanged at the beginning of expiration.

Alveolar: that fraction of the inspired gas volume which, enters the alveoli, but is ineffective in arterialising mixed venous blood.

Physiological: alveolar + anatomical dead space

■ Factors Affecting Anatomical Dead Space

1. body size
2. age
3. lung volume
4. posture
5. drugs - bronchodilators / bronchoconstrictors
   - anaesthetic agents
6. lung disease - emphysema, asthma, CAL
7. IPPV
8. flow pattern - high flows and turbulence increase $V_D$

■ Additional Factors Affecting Alveolar Dead Space

1. blood volume
2. pulmonary artery pressure
3. lung disease
4. IPPV including waveform and PEEP
5. anaesthesia
6. respiratory rate and minute volume
7. oxygen - rise in $P_{A02}$ vasodilatation & increased $V_D$
Bohr Equation (1891)

\[ \frac{V_D}{V_T} = \frac{F_{ACO_2} - F_{ECO_2}}{F_{ACO_2}} \]

- originally used to measure \( F_{ACO_2} \), using estimates of \( V_D^{Anat} \) from autopsy cast specimens
- not used to estimate \( V_D^{Anat} \) until the constancy of alveolar air was established by Haldane and Priestly (1905)
- following this,
  1. \( F_{ACO_2} \) is estimated from ETCO\(_2\) with a rapid gas analyser
  2. the mean expired concentration from a Douglas bag

- this estimated anatomical \( V_D \) as ETCO\(_2\) estimates mean, not "ideal" alveolar CO\(_2\)
- subsequently modified by Enghoff to estimate total, or physiological \( V_D \), viz.

Enghoff Modification (1938)

\[ \frac{V_D^{Phys}}{V_T} = \frac{P_{aCO_2} - P_{ECO_2}}{P_{aCO_2}} \]

Ventilation/Perfusion Relationships

<table>
<thead>
<tr>
<th>Causes of Non-Uniformity</th>
<th>Perfusion</th>
<th>Ventilation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physiological</td>
<td>gravity, PA pressures, posture, exercise</td>
<td>airway closure (FRC &lt; CC), V vs. Q mismatch, posture</td>
</tr>
<tr>
<td>Pathological</td>
<td>hypovolaemia, hypervolaemia, LVF, embolism, regional ↑ PVR, PEEP, drugs</td>
<td>exaggeration of above, regional compliance differences, regional airway resistance change, collapse, consolidation, mucosal oedema, plugging, diffusion block</td>
</tr>
<tr>
<td>Assessment</td>
<td>Ventilation</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>-------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Perfusion</td>
<td>Ventilation</td>
<td></td>
</tr>
<tr>
<td>• CXR</td>
<td>• clinical assessment</td>
<td></td>
</tr>
<tr>
<td>• lung scan</td>
<td>• CXR</td>
<td></td>
</tr>
<tr>
<td>• spiral CT + contrast</td>
<td>• single breath N₂ test</td>
<td></td>
</tr>
<tr>
<td>• pulmonary angiography</td>
<td>• N₂ washout</td>
<td></td>
</tr>
<tr>
<td>• Xe₁³³ washout</td>
<td>• Xe₁³³</td>
<td></td>
</tr>
<tr>
<td>• calculation of $V_D/V_T$</td>
<td>• venous admixture</td>
<td></td>
</tr>
<tr>
<td>• $P_{a-ET}$ CO₂ difference</td>
<td>• $P_{aO_2}$ difference</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• pulmonary function tests</td>
<td></td>
</tr>
</tbody>
</table>

**The Shunt Equation**

\[
\frac{Q_S}{Q_T} = \frac{C_{cO_2} - C_{aO_2}}{C_{cO_2} - C_{T0_2}}
\]

**Alveolar-Arterial Oxygen Tension Gradient**

*Def'n:* normal $P_{A-o_2}$ ≤ 20 mmHg

- where the $P_{A-o_2}$ is given by the alveolar air equation, simplest form,

\[
P_{AO_2} = P_{iO_2} - \frac{P_{aCO_2}}{R}
\]

- rearranging the shunt equation,

\[
\frac{Q_S}{Q_T} = \frac{(C_{cO_2} - C_{aO_2})}{(C_{cO_2} - C_{mO_2})}
\]

\[
C_{aO_2} = C_{cO_2} - (C_{a-mO_2} x Q_S / [Q_S - Q_T])
\]

also,

\[
C_{aO_2} \approx ([Hb] \times 1.34 \times S_{aO_2}) + (0.003 \times P_{aO_2})
\]
therefore, the $P_{A-aO_2}$ is dependent upon,

1. $FIO_2$ and $P_{A02}$ - hyperbolic relationship
2. mixed venous $P_{mVO_2}$
3. cardiac output - inverse relationship
4. $DO_2$ & $VO_2$ - linear relationship
5. pulmonary shunt - linear relationship
6. minor factors
   i. [Hb] & position of dissociation curve
   ii. respiratory quotient
   iii. hypovolaemia

**Pulmonary Gas Exchange**

- $O_2$ diffusion is dependent upon,
  a. $FIO_2$
  b. alveolar ventilation
  c. effective alveolar/capillary exchange area
  d. effective diffusion distance
  e. pulmonary capillary blood flow
  f. mixed venous Hb saturation
  g. position of Hb-O$_2$ dissociation curve

- normal Hb "fully" saturated in 0.3 sec, with a normal transit time of 0.75 s
- factors affecting diffusing capacity,
  a. increased diffusion path length
  b. decreased area - definition of emphysematous lung disease
  c. posture - increased in supine position
  d. exercise
CO₂ Transport

- **Content**
  
  a. arterial ~ **49** ml/100ml
  b. mixed venous ~ **53** ml/100ml
  c. added to capillary blood ~ **3.75** ml/100ml
  
  - by where,
    i. plasma ~ 2.35 ml/100ml **65%**
    ii. rbc ~ 1.4 ml/100ml 35%
  
  - by form,
    i. CO₂ as HCO₃⁻ ~ 2.43 ml/100ml **65%**
    ii. carbamino Hb ~ 1.0 ml/100ml 26%
    iii. dissolved CO₂ ~ 0.3 ml/100ml 8%
    iv. carbamino plasma protein < 1%

- **Haldane Effect**

  **Def’n:** the shift of the Hb-CO₂ dissociation curve with variations in the SaO₂
  
  - effectively reduces the rise in PᵦCO₂ in venous blood,
    thereby limiting the fall in mixed venous pH

<table>
<thead>
<tr>
<th></th>
<th>Arterial</th>
<th>Mixed Venous</th>
</tr>
</thead>
<tbody>
<tr>
<td>P&lt;sub&gt;CO₂&lt;/sub&gt;</td>
<td>40 mmHg</td>
<td>46 mmHg</td>
</tr>
<tr>
<td>C&lt;sub&gt;CO₂&lt;/sub&gt;</td>
<td>49 ml/100ml</td>
<td>53 ml/100ml</td>
</tr>
<tr>
<td></td>
<td>22 mmol/l</td>
<td>24 mmol/l</td>
</tr>
<tr>
<td>pH</td>
<td>7.4</td>
<td>7.37</td>
</tr>
<tr>
<td>P&lt;sub&gt;O₂&lt;/sub&gt;</td>
<td>100 mmHg</td>
<td>40 mmHg</td>
</tr>
<tr>
<td>S&lt;sub&gt;O₂&lt;/sub&gt;</td>
<td>97.5%</td>
<td>74%</td>
</tr>
</tbody>
</table>
**Effects of Hypocapnia**

1. ↑ TPR
2. cerebral vasoconstriction
3. placental vasoconstriction
4. ↓ cardiac output
5. ↓ ICP
6. ↑ pain threshold
7. hypoventilation
8. respiratory alkalosis
9. *left* shift of the HbO$_2$ dissociation curve
10. hypokalaemia $\rightarrow$ ICF shift
11. ↓ HCO$_3^-$ reabsorption by the kidney
12. ↓ plasma ionized Ca$^{++}$ $\rightarrow$ tetany

**Effects of Hypercapnia**

1. cerebral vasodilatation
2. ↑ ICP
3. ↑ CNS sympathetic outflow
4. ↑ cardiac output & BP - indirect effect
5. direct depressant effect upon the CVS
6. cardiac arrhythmias
7. hyperventilation
8. respiratory acidosis
9. *right* shift of the HbO$_2$ dissociation curve
10. hyperkalaemia
11. ↑ HCO$_3^-$ reabsorption by the kidney
CONTROL OF VENTILATION

- **Feedback Mechanism**
  1. sensory mechanisms - central / peripheral
  2. central integration
  3. effector systems

- **Brainstem Influences**
  a. carotid and aortic chemoreceptors - $P_{aO2} / P_{aCO2} / pH$
  b. central CSA - $P_{aCO2}$
     - CSF pH
  c. cerebral blood flow
  d. lung reflexes
     i. Hering-Breuer reflex - inhibitory inspiratory reflex
     ii. paradoxical reflex of Head - inspiratory triggering
     iii. chest wall/parenchymal reflexes
  e. muscle spindles - respiratory muscles
     - not diaphragm
  f. carotid and aortic baroreceptors
  g. thoracic chemoreceptors
  h. peripheral receptors - pain
     - temperature
     - mechanoreceptors
  i. cerebral cortex - emotion
     - voluntary control
     - speech
  j. reticular activating system - SNS
     - olfactory sense
     - speech
  k. hormones - progesterone
  l. drugs - almitrine, ? aminophylline
Peripheral Chemoreceptor Stimulation - Factors

a. ischaemia
b. hypoxia - rectangular hyperbola
   - inflexion at ~ 60 mmHg & maximal ↑ \( V_M \) ~ 32 mmHg
c. increase \( P_{aCO2} \) ~ 10 mmHg
d. decrease in pH ~ 0.1-0.2
e. drugs - cyanide, nicotine
   - lobeline, doxapram

**NB:** not by - anaemia
- carbon monoxide
- methaemoglobinemia *ie. responds to \( P_{aO2} \) not \( C_{aO2} \)

Chemoreceptor Stimulation - Effects

a. ↑ \( V_T \), frequency & \( V_M \)
b. bradycardia - carotid body
c. tachycardia - aortic body
d. hypertension - systemic & pulmonary vasoconstriction
e. bronchoconstriction

Effects of Apnoea

**NB:** \( P_{aCO2} \) → initial rise ~ 6 mmHg in first minute → lung "washin"
→ subsequent rise ~ 1-3 mmHg/min
\( P_{aO2} \) → falls dependent upon \( F_{I2} \), FRC and \( VO_2 \)

- body stores of \( O_2 \) are small, being ~ 1550 ml on air, which corresponds to only 6 mins consumption at a basal \( VO_2 \)
- thus, with changes in \( V_A \) the \( P_{aO2} \) rapidly assumes its new value, the **half time** of change being only 30s
- in contrast the body stores of \( CO_2 \) are large, being ~ 120 l, or 600 mins of the basal output
- the time course of change for \( P_{aCO2} \) is slower for a reduction of \( V_A \) than for an increase
- the half time of rise for \( P_{aCO2} \) ~ 16 mins

- thus, during the **acute phase** of hypoventilation, the \( P_{aO2} \) may be low while the \( P_{aCO2} \) is still within the normal range

**NB:** . during acute hypoventilation, the **respiratory exchange ratio** may fall far below the **respiratory quotient**, which it equals at steady state, as \( CO_2 \) production is partly diverted to the body stores
CO₂ & Ventilation

NB: $\uparrow V_M \approx 2.0 \text{ l/min/mmHg} \approx \uparrow \text{PaCO}_2$

the predominant effects are upon the *central chemosensitive area* CSA
large interpatient variation in slope of the $V_M$/PaCO₂ line

<table>
<thead>
<tr>
<th>Factors Shifting the $V_M$-CO₂ Curve</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Left</strong></td>
</tr>
<tr>
<td>hypoxia</td>
</tr>
<tr>
<td>acidosis</td>
</tr>
<tr>
<td>hyperthermia</td>
</tr>
<tr>
<td>catecholamine release</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

OXYGEN THERAPY

- **Isobaric**
  
  a. *fixed* performance
     - high flow - venturi masks
     - low flow - anaesthetic machine
  
  b. *variable* performance
     - small capacity - nasal specs, Hudson
     - large capacity - O₂ tent, cribs

<table>
<thead>
<tr>
<th>Device</th>
<th>FGF (l/min)</th>
<th>$F_O₂$ %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nasal Canulae¹</td>
<td>2-6</td>
<td>28-44</td>
</tr>
<tr>
<td>Hudson Mask</td>
<td>4</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>55</td>
</tr>
<tr>
<td></td>
<td><strong>10</strong></td>
<td><strong>60</strong></td>
</tr>
<tr>
<td></td>
<td>12</td>
<td>65</td>
</tr>
<tr>
<td>O₂ Tent</td>
<td>7-10</td>
<td>60-80</td>
</tr>
<tr>
<td>Incubator</td>
<td>3-8</td>
<td>20-40</td>
</tr>
<tr>
<td>Head Hood</td>
<td>4-8</td>
<td>30-50</td>
</tr>
</tbody>
</table>

¹ increase $F_O₂ \approx 4\% /$ litre flow of O₂ up to 44%
- **Venturi**

  - delivered \( F_1 O_2 \) is estimated as follows,
    1. 6-8 l/min FGF + entrainment gas \( \sim 40-60 \) l/min total flow
    2. 8 l/min \( O_2 \) + 21% of (40-8) l/min \( \sim 30% F_1 O_2 \)
    3. 10 l/min \( O_2 \) + 21% of (60-10) l/min \( \sim 35% F_1 O_2 \)

  - the actual delivered \( F_1 O_2 \) is determined by,
    1. \( O_2 \)% of FGF and variability of flow
    2. maximal FGF
    3. entrainment ratio
    4. size of \( O_2 \) reservoir
    5. patient peak inspiratory flow rate and minute ventilation

<table>
<thead>
<tr>
<th>Oxygen</th>
</tr>
</thead>
<tbody>
<tr>
<td>MW</td>
</tr>
<tr>
<td>BP</td>
</tr>
<tr>
<td>H(_2)O solubility 37°C (^1)</td>
</tr>
<tr>
<td>H(_2)O solubility 0°C</td>
</tr>
<tr>
<td>Critical temperature</td>
</tr>
<tr>
<td>Critical pressure</td>
</tr>
<tr>
<td>Liquid:gas volume ratio</td>
</tr>
<tr>
<td>Specific gravity (gas)</td>
</tr>
<tr>
<td>Cylinders</td>
</tr>
<tr>
<td></td>
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<td></td>
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</tbody>
</table>

\(^1\) Ostwald solubility coefficient for \( O_2 \) in blood at 37°C

\[ = 0.0034 \text{ ml/100ml blood/mmHg} \]

\[ \therefore \text{at 760 mmHg} = 2.58 \text{ ml / 100 ml} \]

- **Methods of Preparation**

  1. fractional distillation of air by pressure / cooling
  2. electrolysis of H\(_2\)O
  3. Brin process using BaO\(_2\)
Oxygen Toxicity

1. hyperoxic syndromes
   i. optic - neonatal retrolental fibroplasia
   ii. neural - hyperbaric O$_2$ seizures
   iii. pulmonary - tracheobronchitis, ARDS
   ? bronchopulmonary dysplasia

2. normoxic syndromes
   • presence of factors enhancing formation of free radicals at normal O$_2$ tension
   i. excessive phagocytic activity
   ii. reperfusion following ischaemia
   iii. drugs / toxins - paraquat, bleomycin

■ Mechanisms

a. free oxygen radicals
b. oxidation of glutathione
c. lipid peroxidation
d. glycolytic GPDH inhibition
e. altered glutamate & GABA metabolism

• species generated,
  a. superoxide $O_2^-$ + superoxide dismutase $\rightarrow$ hydrogen peroxide
  b. hydrogen peroxide $H_2O_2$ + catalase $\rightarrow$ water
  c. hydroxyl radical $OH^-$ + catalase, or
     + glutathione peroxidase $\rightarrow$ water

• factors influencing O$_2$ toxicity,
  a. increased tolerance with increased levels of,
     i. SOD
     ii. catalase
     iii. glutathione peroxidase
     • pulmonary levels are increased with endotoxin
     • may reduce O$_2$ lung injury in sepsis
  b. decreased tolerance with,
     i. nutritional deficiency - vit. E, C, selenium, glutathione & SH-compounds
     ii. hyperthyroidism
     iii. hypercortisolism
     iv. drugs / toxins
**Pulmonary Oxygen Toxicity**

- first described by J.L. Smith in 1899
- difficult to distinguish from the effects of hypoxia in critically ill patients
- CXR changes are non-pathognomonic
- *inspired oxygen tension* is more important than $F_1O_2$
- tracheobronchitis & $\downarrow$ VC may occur after 12-24 hours breathing 100% $O_2$ at 1 Atm.
- the pulmonary *endothelial cell* is most sensitive, progressing to $\rightarrow$ type I alveolar cells showing damage at $\geq 48$ hrs
- there is considerable patient variation
- an absolute "safe level" of $O_2$ has not been established, but $\leq 50\%$ tolerated for prolonged periods
- two phases,
  1. **acute exudative phase**
     - endothelial oedema, capillary damage & haemorrhage
     - cellular infiltrate
     - reduced compliance & VC
     - $\uparrow$ type I alveolar damage
  2. **late proliferative**
     - type II alveolar proliferation with type I cell destruction
     - leukocyte infiltrate, interstitial fibrosis and septal thickening

- pulmonary oxygen toxicity is hastened by,
  1. higher $F_1O_2$
  2. inhalation of $CO_2$
  3. radiation
  4. paraquat, bleomycin
  5. chemotherapy

- pulmonary oxygen toxicity is delayed by,
  1. brief intermittent exposure to $F_1O_2 = 21\%$
  2. a high $P_{A-aO_2}$ gradient

- secondary cardiovascular changes,
  1. $\uparrow$ SVR & PVR
  2. $\downarrow$ cardiac output
Pulmonary Changes in Early Oxygen Toxicity

1. ↓ VC *most useful
2. ↓ FRC
3. ↓ compliance
4. ↓ CO-diffusing capacity
5. ↑ respiratory rate

- the following factors are not altered in early oxygen toxicity,
  1. RV
  2. airways resistance
  3. $P_{A-aO2}$ gradient

Complications

1. chemical toxicity - tracheobronchial tree, alveolar & endothelial cells
   - pulmonary damage, atelectasis
   - hypoxia, acidosis
2. retinal damage
3. erythrocytic damage, haemolysis
4. hepatic effects
5. myocardial damage
6. endocrine effects
7. renal damage
8. CNS enzyme / cell toxicity - twitching, convulsions, cell necrosis

Organ Systems Susceptible to Oxygen Damage

a. blood-brain barrier, cognition, neuromuscular function
b. glomerular function
c. endocrine function, reproduction
d. vision, auditory-vestibular function
e. hepatic function
f. respiratory function
g. myocardial function
h. haemopoietic function
i. temperature regulation


**Oxygen Limits in Normal Man**

1. $F_1O_2 \leq 55\%$ - safe for indefinite periods
2. 1 Atm. / 24 hours ~ 10% fall in VC
3. $\geq 2$ Atm. / 24 hours - CNS toxicity

**Other Factors: Animal Studies**

a. *factors hastening toxicity*
   i. corticosteroids, ACTH
   ii. $CO_2$
   iii. convulsions
   iv. drugs - paraquat
      - dextroamphetamine
      - adrenaline, noradrenaline, insulin
   v. hyperthermia
   vi. thyroid hormones
   vii. vitamin E deficiency

b. *factors delaying toxicity*
   i. acclimitization to hypoxia
   ii. adrenergic blocking agents, ganglionic blocking agents, reserpine
   iii. antioxidants
   iv. general anaesthesia
   v. chlorpromazine
   vi. GABA, glutathione
   vii. hypothermia, hypothyroidism
   viii. starvation
   ix. vitamin E
   x. immaturity
Oxygen Cost of Breathing

**Def'n:** normal ~ 0.5-1.0 ml.\(O_2\) / litre of ventilation

~ 2-4 ml.\(O_2\) / min

- this is increased by,
  1. exercise
  2. asthma, CAL
  3. cardiac failure
  4. obesity

**NB:** lung disease (\(↓\) compliance / \(↑\) resistance) increases both the **baseline** \(O_2\) consumption and the **slope** of the graph

### SIMV Work of Breathing

- demand flow SIMV systems \(→ \uparrow VO_2 \sim 6-46\% \ (mean \sim 16\%)
- factors in this increase are,
  a. work during IMV
  b. *triggering* of the demand valve
  c. circuit/ETT resistance
  d. isometric contraction prior to reduction of airway pressure
  e. *auto-PEEP*
  f. inefficient action of the diaphragm with *hyperinflation* states
  g. low *compliance* disease states of the lung
  h. insufficient *peak flow* rates during inspiration
Hyperbaric Oxygen

- **Clinical Uses**
  a. decompression sickness *not really hyperbaric O₂*
  b. gas gangrene
  c. other severe anaerobic infections
  d. severe carbon monoxide poisoning
    i. COHb > 40%
    ii. associated cardiorespiratory limitation
  e. cerebral air embolism
  f. research
  g. with DXRT as cancer chemotherapy
  h. surgery - to prolong cardiac arrest time
     - superseded by hypothermia

<table>
<thead>
<tr>
<th>Dissolved Plasma Oxygen</th>
</tr>
</thead>
<tbody>
<tr>
<td>sea level 21 % ~ 0.3 ml</td>
</tr>
<tr>
<td>sea level 100 % ~ 2.1 ml</td>
</tr>
<tr>
<td>2 atm. 100 % ~ 4.2 ml</td>
</tr>
<tr>
<td>3 atm. 100 % ~ 6.3 ml (~ total VO₂)</td>
</tr>
<tr>
<td>αO₂ ~ 0.003 ml / 100ml / mmHg</td>
</tr>
</tbody>
</table>

- **Other Effects**
  a. hypercarbia
    - $P_{O₂} \geq 50$ mmHg $\rightarrow$ ~ no CO₂ bound to Hb  
      **Haldane effect**
    - ↓ buffering capacity $\rightarrow$ ↑ minute ventilation
  b. left shift of HbO₂ dissociation curve
  c. ↑ work of breathing $\rightarrow$ ↑ gas density
  d. pulmonary vasodilatation $\rightarrow$ ↑ $Q_s/Q_t$ $\propto$ loss of HPV
  e. systemic vasoconstriction $\rightarrow$ ↑ diastolic BP
  f. cerebral vasoconstriction
  g. ↓ HR $\rightarrow$ reflex baroreceptor
  h. ↓ cardiac output $\rightarrow$ ? reflex / direct

---

ICU Respiratory

22
ICU - Respiratory

- **Other Effects 100% O₂**
  a. absorption atelectasis - lung
     - middle ear
     - pneumothorax
  b. \( \uparrow P_{A\text{-a}O_2} \) gradient
  c. reduces the effect of low V/Q areas but *increased shunt fraction*
  d. \( \uparrow O_2 \) stores, apnoea time ~ FRC/VO₂
  e. O₂ toxicity

- **Hazards**
  a. fire, explosion
  b. pulmonary O₂ toxicity
  c. cerebral O₂ toxicity - convulsions, coma
  d. avascular bone necrosis head of femur
  e. barotrauma - middle ear
     - lung
  f. "bends" if removed rapidly
  g. retrolental fibroplasia
  h. CO₂ narcosis - CAL
     - high altitude dwellers
     * loss of hypoxic drive

<table>
<thead>
<tr>
<th>HYPOXIA</th>
<th>( P_{aCO_2} )</th>
<th>( \delta P_{A\text{-a}O_2} )</th>
<th>( \delta P_{aO_2} ) 100%</th>
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</thead>
<tbody>
<tr>
<td>low F_{I}O₂</td>
<td>low</td>
<td>low</td>
<td>large increase</td>
</tr>
<tr>
<td>hypoventilation</td>
<td>high</td>
<td>normal</td>
<td>large increase</td>
</tr>
<tr>
<td>V/Q mismatch</td>
<td>normal</td>
<td>high</td>
<td>large increase</td>
</tr>
<tr>
<td>low D_{O₂}</td>
<td>normal</td>
<td>high</td>
<td>increase</td>
</tr>
<tr>
<td>R→L shunt</td>
<td>normal</td>
<td>very high</td>
<td>small increase</td>
</tr>
</tbody>
</table>
Humidification

- **Complications**
  1. bulk, complexity
  2. condensation
     - "rain-out", drowning
     - ↑ resistance
     - scalding
     - circuit valve malfunction
     - decrement in filter function
  3. over-spill of water
     - scalding
     - pulmonary oedema
  4. bacterial contamination
  5. high compliance
  6. high resistance
  7. overheating
  8. electrocution
  9. disconnection sites

- **Consequences of Dry Gases**
  1. heat loss
     - ≤ 1-3°C/hr
  2. water loss
     - impaired mucociliary escalator
     - mucociliary damage
     - mucosal desquamation, ulceration
     - drying of secretions, sputum retention
  3. altered lung mechanics
     - ↓ FRC
     - ↓ compliance
     - ↑ shunt fraction
     - ↓ $P_{aO2}$
     - bronchoconstriction
  4. increased incidence of *respiratory infections*
Heat & Moisture Exchangers

■ **Advantages**
  
  a. cheap, simple, lightweight, silent, reliable
  
  b. disposable, no energy source
  
  c. bacterial filtration, low dead space & resistance
  
  d. useful for,
     
     i. children and adults
     
     ii. transport, retrievals
     
     iii. tracheostomy, spontaneous ventilation via ETT

■ **Disadvantages**
  
  a. inefficient with high minute volumes & gas flows
  
  b. inefficient after 1-2 hours
  
  c. airways resistance / dead space significant for small children
  
  d. potential for disconnection or obstruction
INTUBATION

- **CVS Response**
  a. hypertension - $\uparrow$ MAP ~ 20-40 mmHg
     * may have up to 60% $\uparrow$ MAP
  b. tachycardia - $\uparrow$ HR ~ 50%
  c. arrhythmias
  d. $\uparrow$ ICP - up to 100%
  e. ↓ uterine blood flow

**NB:** potential for,
   i. myocardial ischaemia / infarction
   ii. LVF
   iii. intracranial hypertension / haemorrhage
   iv. foetal hypoxia
   v. eclampsia

- methods for minimising CVS changes,
  a. rapid laryngoscopy $\leq$ 45 secs
  b. avoid vasoconstrictors - ketamine
     - cocaine
     - adrenaline, POR8
  c. adjuvant dose of STP
  d. deep volatile anaesthesia
  e. fentanyl $\sim$ 5-10 µg/kg 5-7 min pre-ETT
  f. lignocaine $\sim$ 1.5-3.0 mg/kg 2-3 min pre-ETT
  g. nitroprusside $\sim$ 0.5 µg/kg 30 secs pre-ETT
  h. hydrallazine $\sim$ 5-10 mg 5-10 min pre-ETT
  i. GTN
     i. paste 5cm (30 mg) 15 mins
     ii. infusion 0.1% 20 mins
     iii. IV bolus 50-250 µg 30 secs
  j. $\alpha / \beta$-blockade - phentolamine 1-5 mg
     - propranolol 1-4 mg
     - esmolol 2-4 mg bolus or infusion
  k. trimethaphan - 0.7 mg/kg bolus
     - then 0.1-0.4 mg/kg over 10 mins
**Indications**

1. upper airway obstruction
2. airway protection - gastrointestinal contents - blood or secretions
3. application of mechanical ventilation
4. inability to clear secretions
5. to enable specific therapy
   i. induced hypocapnia
   ii. high $F_1O_2$ / PEEP
   iii. pulmonary toilet / lavage
   iv. BAL

**Complications**

a. **immediate**
   i. laryngoscopy - trauma
      - aspiration
      - autonomic reflexes
   ii. ETT - misplacement
       - obstruction / kinking / disconnection
   iii. cuff - herniation
       - overinflation
       - perforation, leakage

b. **short-term** (hours-days)
   i. obstruction - endobronchial misplacement
      - obstruction / kinking
      - overinflation, herniation
   ii. dislodgement / disconnection
   iii. colonization - sinusitis, tracheitis
      - nosocomial pneumonia
   iv. dry gases - dehydration
      - hypothermia
      - thickened secretions, inspissation

c. **long term** (days-weeks)
   i. laryngeal trauma
   ii. tracheal trauma
   iii. infections - sinusitis, otitis
      - tracheitis, nosocomial pneumonia
      - microaspiration, lung abscess
      - septicaemia
Difficult Intubation

- **Physiological**
  
  a. short muscular neck
  b. receding mandible
  c. prominent upper teeth
  d. narrow mouth with high arched palate
  e. limited jaw opening
  f. large breasts
  g. anterior larynx
  h. effective mandibular length - thyromental distance
  i. receding lower jaw / maxillary protrusion
  j. short occipito-atlantis distance
  k. short C1-C3 distance

- **Pathological**
  
  a. TM joint disease - RA
     - trismus
     - fracture
  b. limited cervical extension - trauma, fracture
     - spondylitis
     - RA
  c. oropharyngeal masses - tumours
     - oedema
     - abscess, cysts
  d. contractures of face/neck - burns, scars
     - tumours
  e. trauma - mandibular, facial bones
     - cervical spine
     - larynx
     - airway bleeding
  f. congenital - craniofacial disorders
     - macroglossia, Down's
     - encephalocele
     - cleft palate
  g. endocrine - obesity
     - acromegaly
     - goitre
Assessment of Airway

1. **history**
   i. letters etc. re previous difficult intubation
   ii. previous anaesthetic records

2. **examination → "MOUTHS"**
   i. **M**andible
      - thyromental distance > 6 cm, or > 3 "finger-breadths"
      - alveolar-mental distance < 2 cm
      - "receeding", length
      - subluxation
      - obtuse mandibular angles
   ii. **O**pening
      - incisor gap > 4 cm
   iii. **U**vula
      - Mallampati grades I-IV - as per Samsoon & Young
   iv. **T**eeth
      - prominent upper incisors, "buck" teeth
      - solitary incisors, "nuisance" teeth
      - loose teeth
      - crowns, caps, plates & dentures
   v. **H**ead & Neck
      - flexion, extension, lateral flexion & rotation
      - tracheal position, neck masses, upper mediastinal masses
   vi. **S**ilhouette
      - obesity
      - Dowager's hump
      - "no neck"
      - craniofacial anomalies

3. **investigations**
   i. awake laryngoscopy - direct or indirect
   ii. fluoroscopy
   iii. XRays (Bellhouse)
      - mediastinal masses & tracheal position / diameter
      - effective mandibular length
      - atlanto-occipital distance & C1-C2 interspace
      - anterior-posterior thickness of the tongue
   iv. CT scan
      - tracheal deviation, luminal diameter
      - intrathoracic trachea, mediastinal masses
VENTILATION

- **claimed advantages** of IMV over CMV,
  a. minimises respiratory alkalosis
  b. minimise sedative/relaxant requirements
  c. lower mean airway pressures
  d. more uniform gas distribution
  e. expedite weaning process
  f. reduce muscle atrophy & dis-coordination
  g. reduce cardiac decompensation with weaning

- possible **disadvantages**.
  a. risk of hypercarbia, cf. with AMV
  b. increased work of breathing
  c. respiratory muscle fatigue
  d. prolonged ventilation if rate reduced too slowly
  e. cardiac decompensation in patients with compromised cardiac function

- Groeger (CCM, 1989), SIMV vs. assist control → advantages of SIMV
  1. lower $P_{IP}$
  2. improved - CO & MAP
     - $DO_2$
     - LVSWI
  3. less alkalosis

**NB:** SIMV was associated with a *higher* respiratory rate, despite similar minute volumes and oxygen consumption
IPPV and Muscle Relaxants

**Short Term**

1. masking of clinical signs
   i. level of consciousness
   ii. epilepsy, neurological change
   iii. acute abdomen, etc.
2. inadequate analgesia and sedation
3. impaired secretion clearance - loss of cough reflex
4. histamine release, anaphylaxis / anaphylactoid reactions
5. asphyxia from circuit malfunction

**Long Term**

1. muscle wasting & atrophy
   - ↑ negative nitrogen balance
   - difficulty in weaning
   - ? myopathy associated with steroid use, especially in status asthmaticus
   - ?? predisposition to CIP, but EMG changes are dissimilar
2. DVT & pulmonary emboli - need for prophylaxis/anticoagulation
3. pressure sores
4. drug metabolite accumulation - laudanosine
   - M₆G

**Advantages**

1. tolerance of mechanical ventilation - particularly PCIRV
2. tolerance of hypercarbia
3. avoidance of - breath stacking
   - high peak $P_{AW}$ ? theoretically may not matter
   - inadequate ventilation
4. reduction in $VO_2$
5. in infants - improved oxygenation
   - reduced inspiratory time
   - reduced barotrauma
6. $R_X$ in patients with raised ICP
7. less baro/volutrauma ? evidence for this
8. ? neurophysiological studies
Special Indications

a. infant respiratory distress syndrome,
   • decreased pneumothorax rate
   • **no change** in intraventricular haemorrhage rate
   • **no change** in mortality

b. cerebral disorders
   • less rise in ICP with various stimuli
   • **no change** in ICP rise with **pain**
   • less sedation required therefore aiding CNS assessment
   • less indication now propofol allows adequate sedation & periodic assessment
   • recent article in ?J.Trauma showing ↑mortality in NMJ paralysis group for management of severe head injury

c. tetanus

d. severe acute asthma

e. severe restrictive respiratory deficits, ARDS

f. ? cardiogenic shock to reduce VO$_2$
IPPV Adverse Effects

a. respiratory
   i. barotrauma - alveolar rupture, PIE
      - pneumomediastinum / pneumothorax
      • alveolar overdistension - hyaline casts, ? fibrosis
   ii. surfactant loss / inactivation
      • ↓ FRC and encroachment of CC on FRC
   iii. ↑ lung water ∝ ? ↓ lymphatic drainage
        ? ↑ LAP
      • disproportionate effect on PV & PA pressures → ↑ P_{pc}
   iv. ↑ V/Q mismatch - ↑ Q_s, V_d & regional alkalosis
      - low flow areas & regional ischaemia
   v. frequently associated with potentially toxic F_{1}O_{2}

b. cardiovascular
   i. RV effects ↓ venous return
      ↑ PVR & RV afterload
      ↑ RVEDV
      ↓ RV perfusion pressure
   ii. LV effects ↓ LV afterload
      ↓ LVEDV
      * ventricular interdependence
   iii. dual effects - global cardiac compression
      ? ↓ coronary blood flow (most studies → no change)
   iv. ↓ VO_{2}
   v. ↓ inspiratory muscle blood flow

c. renal
   i. ↑ ADH / ↓ ANF secretion → ↓ urine output and Na^+ excretion
   ii. redistribution of intrarenal blood flow
   iii. ↑ IVC & renal vein pressure

d. CNS
   i. ↑ ICP
      • unpredictable, but clinically insignificant at levels of PEEP ≤ 10 cmH_{2}O
   ii. ↓ cerebral blood flow ∝ induced hypocapnia

e. hormonal
   i. ↑ plasma adrenaline and noradrenaline
   ii. ↑ ADH / ↓ ANF
   iii. ↑ renin & aldosterone
      • most of these effects are reversed with volume replacement
Assessment of Respiratory Function During IPPV

1. **Clinical**
   i. signs of hypoxia - tachycardia, hypertension, cyanosis
   ii. signs of hypercarbia - bounding pulse, tachycardia

2. **Shunt fraction**
   - AaDO$_2$, PaO$_2$;F$_1$O$_2$ ratio
   - shunt equation

3. **Dead space**
   \( \Delta P_{acO_2} : V_M \)

4. **Lung volumes**
   \( * VC \geq 15 \text{ ml/kg} \)

5. **Respiratory rate**
   \( \leq 30 \text{ bpm} \)

6. **Compliance**
   \( \approx \frac{\delta V_t}{(P_{MAW} - [PEEP + autoPEEP])} \geq 75 \text{ ml/cmH}_2\text{O} \)

**Intrinsic PEEP** present in most ventilated patients,
   i. ARDS \( \geq 8 \text{ cmH}_2\text{O} \)
   ii. ARF \( \approx 4 \text{ cmH}_2\text{O} \)

   \( \rightarrow \) **underestimation** of compliance by \(~ 20-30\%\)

7. **Resistance**
   \( \approx \frac{(P_{max} - P_{p1})}{\text{flow}} \)
   \( \approx 2-6 \text{ cmH}_2\text{O/l/s} \leq 10-15 \text{ cmH}_2\text{O} \) (NMJB/ETT)

8. **MMV**
   \( \approx 2 \times V_M \)

9. Maximal inspiratory occlusion pressure
   \( MIP_{0.1} \geq -20 \text{ cmH}_2\text{O} \)

10. **f / V_T > 100** \( \rightarrow \) not ready to wean \( (V_T \text{ in litres}) \)

**Pressure Support**

- optimal pressure support is influenced by,

  a. **Ventilator factors**
     i. size of ETT
     ii. ventilator circuit - demand valves
     - tubing resistance / compliance
     \( \pm \) humidifier
     iii. ventilation mode - CMV, IMV, CPAP
     iv. trigger method & sensitivity

  b. **Patient factors**
     i. airways resistance
     ii. respiratory compliance
     iii. respiratory rate
     iv. minute volume
     v. muscle strength
CPAP Circuits

- **Benefits**
  
  a. $\uparrow$ FRC $\rightarrow$ *alveolar recruitment*
  b. improved V/Q match
  c. improved oxygenation
  d. $\downarrow$ work of breathing
     i. $\uparrow$ compliance
     ii. $\downarrow$ inspiratory muscle work
     iii. $\downarrow$ autoPEEP *some, not all patients*
  e. "open lung" theory

- **Other Effects**
  
  a. $\downarrow$ LV afterload
  b. $\downarrow$ venous return in CCF, acute LVF
  c. redistribution of lung water out of alveoli
     • however, total lung water *increases*

- **Clinical Uses**

  1. low FRC states
     i. ARDS
     ii. IRDS
     iii. acute pulmonary oedema
     iv. diffuse interstitial lung disease
     v. pneumonitis
     vi. bronchiolitis
  2. high autoPEEP states
     i. asthma
     ii. CAL
- **CPAP** *Potential Disadvantages*

  a. excessive ↑ FRC
  b. ↑ work of breathing
  c. ↓ venous return
  d. patient discomfort
  e. gastric distension / aspiration
  f. skin / nasal bridge necrosis

  **NB:** the work of breathing is proportional to the $\delta P_{AW}$, where,

  $\delta P_{AW} \propto \text{resistance} \& \text{reactance}$

  \[
  \text{resistance} = \frac{\text{pressure}}{\text{flow}} \\
  \text{reactance} = (\text{inertia} \times \text{acceleration}) - (\text{volume} \div \text{compliance})
  \]

  - therefore, the work of breathing through a CPAP circuit is affected by,

  1. flow $< \text{PIFR}$ $\rightarrow$ ↑ $W_{BR}$  $>$ PIFR $\rightarrow$ ↑ turbulence
  2. ↑ resistance  - narrow tubing  
     - demand valves  
     - flow resistors
  3. gas inertia & circuit geometry
  4. gas acceleration
  5. bag compliance
Inverse I:E Ratio

- claimed advantages,
  a. adequate ventilation without high peak inspiratory pressures
  b. less barotrauma
     • not substantiated in RCTs where mean $P_{AW}$ has been equal
  c. use of a lower $F_{O_2}$

  **NB:** assumption, peak $P_{AW} > 60$ cmH$_2$O and $F_{O_2} > 0.6$,
     → probably cause damage unless very brief

- Lachmann, **lung lesion index**, 
  \[ LLI = \frac{P_{aO_2}}{(F_{O_2} \times P_{AW})} \]
  \[ \leq 4 \text{ suggests high probability of lung damage} \]

- main aims of ventilation during ARDS are,
  a. restoration/maintenance of FRC
  b. maximise *recruitment* of functional gas exchange units
  c. minimise *barotrauma*

- the respiratory pressure/volume curve changes throughout the disease process, therefore one ventilator setting may not be the best
- the justifications for reversing the I:E ratio include,
  a. overcome the critical opening pressure during inspiration
  b. sustain opening pressure
  c. expiratory time short enough to prevent closure of lung units

- additional PEEP is usually required but is low, ~ 4-8 cmH$_2$O

  **NB:** the *autoPEEP* produced may be profound, ~ 8-16 cmH$_2$O

- Lessard *et al.* (Anaesthesiology 1994) review of PCIRV versus conventional ventilation, controlling for mean airway pressures & PEEP, showed no advantage for the former with respect to,
  1. oxygenation
  2. barotrauma
Positive End-Expiratory Pressure

_NB:_ the important therapeutic change is an _increase in FRC_

### Possible Beneficial Effects

_NB:_ dependent upon the level of PEEP

a. respiratory
   - ↑ transpulmonary pressure → ↑ end-expiratory lung volume / FRC
   - ↑ lung compliance
   - ↓ V/Q mismatch / ↓ shunt → ↑ $P_{aO2}/C_{aO2}$ ??DO$_2$
   - conflicting information on $V_d/V_T$
   - reduced _apnoeic periods_ in infants and sleep apnoea patients
b. CVS
   - ↑ stroke volume / ↓ LVESV
   - ?? reversal of LVF

### Adverse Effects

_NB:_ especially if excessive PEEP

a. respiratory
   - adverse redistribution of blood flow → diseased lung
   - ↓ lung compliance
   - ↑ in total lung water
   - barotrauma, alveolar rupture/pneumothorax
   - inactivation of surfactant
b. CVS
   - ↑ pulmonary capillary pressure
     - $P_c = \text{LAP} + 0.4(P_{mPA} - \text{LAP})$
     - PEEP increases LAP & $P_{mPA}$
     - $P_c$ increases ~ 0.5 x PEEP, assuming $C_L \sim C_{CW}$
   - ↑ RV afterload
   - ↓ cardiac output / ↓ venous return
   - ventricular interdependence
   - humoral factors → ↓ ANF / ↑ ADH
   - global cardiac compression
   - ? decreased coronary blood flow - disproved in most studies
c. renal
   - ↓ urine output / Na⁺ excretion
   - ↑ ADH, ↓ ANP
   - ↑ IVC, renal vein pressure
   - redistribution of intrarenal blood flow

d. CNS
   - ↑ ICP - unpredictable
   - ? decrease in CBF

e. hormonal
   - ↑ adrenaline, noradrenaline ~ 3x after 5 min of 20 cmH₂O
   - ↑ renin, aldosterone
   - ↑ ADH (conflicting data)
   - ↓ ANP

NB: most of these effects are reversible with volume replacement
Optimal PEEP

**Def’n:** "that level of PEEP which provides the maximal increase in $O_2$ flux"

first coined by Suter *et al.*, NEJM 1975

- schools of thought actually vary as to the *end-point*,
  1. **Suter** (NEJM, 1975)
     - maximum $DO_2$
     - also happened to equate with best compliance
     * however, this was not substantiated by later studies
  2. **Gallager, Civetta** (CCM, 1978)
     - pulmonary shunt fraction $\leq 15\%$
     - used fluid loading and inotropes to maintain cardiac output
     - PEEP required ranged from 15-65 cmH$_2$O !!!
  3. **Carroll** (Chest, 1988)
     - minimal PEEP with $P_{aO2} > 60$mmHg / $F_O2 \leq 0.5$
     - aimed at avoidance of hypoxia and barotrauma
     - claimed "maximal" PEEP of no benefit and
       increases the risk of barotrauma
  4. other terms
     i. *best PEEP*
     ii. *minimal effective PEEP*

**NB:**
  1. practically, where PEEP $\leq 10$cmH$_2$O, most patients benefit in terms of FRC
     and $P_{aO2}$ without significant adverse effects
  2. adverse effects are minimal if the patient has an adequate BP, peripheral
     perfusion and renal output (UO, Cr/Ur)
  3. where PEEP $> 10$cmH$_2$O, or the patient is critically-ill (sepsis, MODS,
     multiple trauma), $O_2$ flux and haemodynamic variables should be calculated
     to optimise PEEP

- **Consensus Statement ICM 1994**

  - beneficial effects of PEEP,
    1. lung recruitment
    2. elevation of $P_{mAW}$
    3. improved oxygenation

**NB:** assessment of "best" level of PEEP depends upon physiological response desired;

"most agree that in ARDS the *lower limit* should be set at, or slightly above the
*inflexion point* of the pressure-volume curve"
AutoPEEP

- causes of **dynamic hyperinflation**.
  1. ↑ airways resistance - bronchospasm, asthma, CAL  
     - bronchomalacia  
     - dynamic airways collapse  
     - foreign body
  2. tachypnoea
  3. inspiratory muscle activity during expiration (asthma)
  4. glottic closure during expiration
  5. mechanical ventilation
  6. resistance of ETT, circuit

- present in most ventilated patients → **underestimates** of compliance by 20-30%
  a. ARDS ~ 8 cmH\textsubscript{2}O (AB says virtually zero in ARDS patients)
  b. ARF ~ 4 cmH\textsubscript{2}O

- **static autoPEEP** monitored by measurement of airways pressure after **end-expiratory occlusion**
- **dynamic autoPEEP** monitored by oesophageal balloon or intrapleural catheter & δ\textsubscript{IP} prior to the onset of gas flow
- dynamic autoPEEP generally 2-3 cmH\textsubscript{2}O < static, and thought to be more clinically relevant
- effects of end-expiratory occlusion,
  a. dynamic hyperinflation
  b. decrease compliance & under-estimation of static compliance by ~ 50%,
     \[ \text{Compliance} = \frac{\delta V_l}{[P_2 - (PEEP + autoPEEP)]} \]
     \[ \approx \frac{\delta V_l}{P_{AW}} \]
     \[ \approx 75 \text{ ml/cmH}_2\text{O} \times (N) \]
  c. ↑ work of breathing
  d. barotrauma
  e. CVS and renal effects of conventional PEEP

**Treatment**

1. treat bronchospasm & clear secretions
2. ↓ I:E ratio → long expiratory times
3. ↓ circuit resistance
4. CPAP - maintain airways open  
   - ↓ inspiratory activity & ↓ inspiratory threshold load  
   - ↓ LV afterload  
   - facilitate weaning
High Frequency Ventilation

<table>
<thead>
<tr>
<th>Method</th>
<th>Frequency Range</th>
<th>Ventilation Rate</th>
<th>Hz</th>
</tr>
</thead>
<tbody>
<tr>
<td>IPPV</td>
<td>&lt; 60 bpm</td>
<td>&lt; 1.0 Hz</td>
<td></td>
</tr>
<tr>
<td>HFPPV</td>
<td>60 - 110 bpm</td>
<td>1.0 - 1.8 Hz</td>
<td></td>
</tr>
<tr>
<td>HFJV</td>
<td>110 - 400 bpm</td>
<td>1.8 - 6.7 Hz</td>
<td></td>
</tr>
<tr>
<td>HFO</td>
<td>400 - 2400 bpm</td>
<td>6.7 - 40 Hz</td>
<td></td>
</tr>
</tbody>
</table>

### Advantages

- a. less movement of the operating field
- b. adequate \( \text{O}_2 \) & \( \text{CO}_2 \) exchange
- c. adequate gas exchange where IPPV complicated or impossible,
  - i. bronchopleural fistula
  - ii. communicating lung cyst
  - iii. tracheal surgery
- d. lower peak airway pressures
  - i. less barotrauma
  - ii. *no studies* showing more beneficial than IPPV/PEEP in ARDS
- e. surfactant not damaged
- f. less effect upon cardiac function
- g. volume and clearance of secretions increased

### Disadvantages

- a. requires expensive equipment and trained personnel
- b. the increased volume of *secretions* may be detrimental
- c. *humidification* difficult
- d. \( \text{CO}_2 \) _exchange_ dependent upon resistance to mass flow and diffusion,
  \( \rightarrow \) limited at high frequencies, \( ? > 20 \text{Hz} \)
- e. \( \text{O}_2 \) _exchange_ proportional to mean lung volume, ie. maintenance of FRC important
  \( \rightarrow \) _mean_ intrathoracic pressure similar to IPPV/PEEP
- f. resonant frequency may be reached in some alveoli,
  \( \rightarrow \) ? resulting in increased barotrauma

*NB:* high frequency ventilation appears very effective at removal of \( \text{CO}_2 \) over a wide range of frequencies, however *oxygenation* appears more dependent upon lung volume and therefore mean airway pressure
Mechanisms of Gas Movement

1. convection - simple in large airways
   - complex at bifurcations & in expiration
2. diffusion
3. pendelluft

Extracorporeal Membrane Oxygenation (ECMO)

- the overall average mortality from ARDS ~ 50-70%
- hypoxia is rarely the cause, usually due to MODS or septicaemia
- this implies that current ventilation modes either,
  1. are adequate and other factors need to be addressed
  2. prevent more rapid lung recovery and allowing more time for extrapulmonary complications to develop

- in ARDS to main problem is hypoxia due to increased shunting
- the small areas of near normal lung have to do the "work" of the whole lung
- this requires therapy with a high F\textsubscript{O}2, high PEEP, and high P\textsubscript{IP}, with their iatrogenic complications

Extracorporeal Lung Assist (ECLA) Terminology

- ECMO
- EC-CO\textsubscript{2}-R
- PE-CO\textsubscript{2}-R

- it is necessary to define,
  1. the type of bypass - VV probably better than AV
  2. bypass flow:CO ratio ~ 20-30% of CO adequate for EC-CO\textsubscript{2}-R
  3. lung ventilatory mode

- clinical studies of EC-CO\textsubscript{2}-R include a total of 115 patients in 8 trials
- there were a total of 57, ~ 50% survivors
- improvement was usually rapid, within the first 48 hours
- the average duration of therapy was ~ 7 days
- when conventional ventilation → total static lung compliance ≤ 25 ml/cmH\textsubscript{2}O
  → survival ~ 0

- this may improve to ~ 50% with EC-CO\textsubscript{2}-R
- subsequent studies have shown no improvement in survival cf. conventional ventilation
Complications of ECMO

1. anti-coagulation and bleeding ~ 1000 ml/d
2. complement activation
3. cost - manpower & equipment

Potential Advantages

a. avoids lung hypoxia, maintains a high lung O\textsubscript{2} supply
b. avoids high airway pressures - ↓ barotrauma
   - ↓ surfactant loss
c. reduction in PA pressure - ↓ HPV
   - reduced effects of PEEP/IPPV
d. correction of V/Q ratios - all areas equally oxygenated
   - avoids regional alkalosis
e. ? anticoagulation reduction of intrapulmonary thrombosis
f. ? reduced incidence of septicaemia
TRACHEOSTOMY

**Indications**

1. prolonged intubation > 7-10 days
   > 2-3/24 in professional singer
2. early for condition where extended airway management highly likely
3. upper airway obstruction
   i. failed intubation
   ii. elective for threatened impossible intubation
   iii. transport of critically ill patient
   iv. postsurgical where re-intubation is likely impossible
      • laryngectomy, radical neck procedures
      • maxillofacial procedures with jaw wiring
   v. traumatic upper airway disruption
      • laryngeal fracture, tracheal disruption

**Advantages**

1. reduced dead space
2. improved patient tolerance → less sedation required
3. removal of secretions
4. reduced incidence of laryngeal injury

**Complications**

1. procedural - haemorrhage
   - misplacement
   - hypoxia
   - pneumothorax / pneumomediastinum
2. decannulation, disconnection
3. colonization, infection
4. with tube - cuff herniation
   - obstruction
   - displacement
5. long term - ulceration, erosion
   - fistula
   - tracheomalacia
   - granulomata, stenosis
   - haemorrhage

45
Clinical Studies

- **El Naggar 1976**
  - 56 patients with an early tracheostomy (day 3)
  - showed an increase in *colonisation* rate but no increase in infections
  - increased frequency of airway lesions but all resolved in time
  - laryngeal trauma from ETT was progressive after day 11
    → therefore recommended tracheostomy at **day 10**

- **Stauffer 1981**
  - large study with 150 patients suggested ETT safer than tracheostomy ≤ 3/52
  - however, a non-randomised study with bias, as the tracheostomy group,
    a. were sicker
    b. were intubated longer
    c. tracheostomised later
    d. different surgeons
    e. high complication rate
      i. infection 36%
      ii. haemorrhage 36%
      iii. wrong incision 8% !!
      iv. cardiac arrest 4%
    f. *stenosis* criterion was too strict, only 10% narrowing, therefore,
      i. tracheostomy group ~ 65%
      ii. ETT group ~ 20%

- **Dunham 1984**
  - total of 74 trauma patients managed with either,
    a. ETT for 14 days, or
    b. tracheostomised on day 3
    → **no difference** in laryngotracheal trauma, sepsis, or morbidity
Whited 1984

- total of 200 patients with ETT,
  a. duration < 5 days ~ 6% transient injury
  b. 6-10 days ~ 5% reversible laryngeal stenosis
  c. > 11 days ~ 12% extensive laryngeal stenosis

- conclusions,
  1. tracheostomy has many potential therapeutic advantages
  2. laryngeal injury after 6-10 days becomes significant
  3. tracheal stenosis is more easily treated than laryngeal stenosis
  4. the high incidence of infectious and laryngeal complications in part relates to the preceding prolonged ETT
  5. maintain on ETT for 7-10 days then tracheostomy if not contraindicated

Berlauk 1986

- factors affecting laryngotracheal injury,
  1. duration of intubation
  2. cuff shape and pressure
  3. tissue compatibility of tube & cuff

- areas of damage from ETT,
  1. posteromedial portion of true cords
  2. posteromedial surface of the arytenoid cartilages
  3. posterolateral surface of cricoid cartilage
  4. mucosa of 4-7th tracheal cartilages
  5. anterior wall of the trachea

- pathology of injury,
  a. ulceration, perforation
  b. ischaemia necrosis
  c. mucosal hypertrophy & granuloma formation
  d. adhesions, fibrosis, stenosis
Kopp 1987

- intubation injuries related to,
  1. duration
  2. hypotension
  3. severity of underlying disease

- no correlation found with hypoxia or steroids
- complications and overall incidence,
  a. glottic oedema - 100%
  b. glottic granuloma - 96%
  c. superficial ulceration of the arytenoids - 81%
  d. mucosal ulceration of the cricoid - 75%
  e. dilatation of the posterior commissure - 60%
  f. deep mucosal ulceration of the arytenoids - 37%
  g. cartilage ulceration of the arytenoids - 24%
  h. cartilage ulceration of the cricoid - 12%
  i. glottic maceration - 6%
  j. glottic synechia - 3%
  k. fracture of the arytenoids - 3%

- higher incidence than previous studies
- severity of injury increased significantly after day 3

NB: concluded, "conversion to tracheostomy should be considered between day 4 & 7 of intubation"

- incidence of hoarse voice,
  a. on extubation ~ 100%
  b. at 1 week ~ 45%
  c. at 1 month ~ 16%
  d. permanent ~ 1.5%
**Tracheostomy: Haemorrhage**

- tracheo-arterial fistula usually involves the,
  a. **innominate artery** ~ 70%
  b. common carotid artery ~ 4%

- most common site is at the cuff, *may* be decreased by high volume/low pressure cuffs
- fistulas related to the stoma are more common if performed below the 4th tracheal cartilage
- not yet reported as a complication of percutaneous tracheostomy
- **overinflation** of the balloon will tamponade bleeding in 80% of cases, *first step*

**Stenosis Summary**

a. tracheostomy
   i. strict criteria ~ 98%
   ii. $\geq$ 30% stenosis ~ 36% ("30% in 30%")
   iii. $\geq$ 70% stenosis ~ 11% (symptomatic)

b. ETT $\geq$ 3 weeks ~ 19%
   $\leq$ 0.5% symptomatic

*NB: but:* less tracheal, more laryngeal injury, which is more difficult to treat


- 5-year burn center experience with tracheostomies $\rightarrow$ 99 tracheostomies (n=3246)
- indications of prolonged respiratory failure or acute loss of airway
- sputum colonization was universal, however rates of pulmonary sepsis & mortality were *not* significantly increased
- 28 patients developed late upper airway sequelae,
  a. tracheal stenosis - TS
  b. tracheoesophageal fistula - TEF
  c. tracheoarterial fistula - TAF

*duration* of intubation correlated only with development of TAF
- TEF patients were significantly older and more likely to have evidence of tracheal necrosis at the time of tracheostomy
- the pathogenesis of upper airway sequelae in these patients
  $\rightarrow$ divergent responses to inhalation injury, infection, and intubation

*NB:* use of tracheostomies in burned patients with inhalation injuries is now reserved for *specific indications*, rather than as prophylactic airway management
**Mortality**

- **Tracheostomy**
  - i. elective ~ 0.4-3%
  - ii. emergency ~ 6-15%
- **ETT > 3 weeks** < 1%

### Tube Characteristics

<table>
<thead>
<tr>
<th></th>
<th>Red Rubber</th>
<th>PVC, Silastic</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tracheal Loading Force</strong>&lt;sup&gt;1&lt;/sup&gt;</td>
<td>1000 g</td>
<td>200-500 g 100-250 g after 24 hrs (moulding)</td>
</tr>
<tr>
<td><strong>Cuff Pressure</strong></td>
<td>~ 120 mmHg</td>
<td>≤ 20 cmH₂O</td>
</tr>
</tbody>
</table>

<sup>1</sup> force exerted in deformation of the tube to the anatomy of the upper airway
PULMONARY BAROTRAUMA

**Def'n:** the side effects of high airway pressures during IPPV

→ air outside the alveolar space

now probably inappropriate, trend toward "volutrauma"

• traditional risk factors during IPPV,
  1. large tidal volume
  2. high mean and peak inspiratory pressures $> 50 \text{ cmH}_2\text{O}$
  3. high levels of PEEP
  4. volume cycled ventilators
  5. short expiratory time - especially with increased resistance
  6. low lung compliance *CAL, ARDS, ?asthma

- **Clinical Features**

  a. interstitial emphysema
     • small parenchymal cysts
     • linear air streaks radiating toward the hilum
     • perivascular haloes
     • intraseptal air
     • pneumatoceles
     • subpleural air
  
  b. pneumothorax
     i. simple
     ii. loculated - anterior, subpulmonic
     iii. tension
  
  c. mediastinal emphysema
  
  d. subcutaneous emphysema
  
  e. pneumatoperitoneum
  
  f. deterioration in lung function 2° surfactant inhibition
Peak Airways Pressure and *Ventilator Associated Lung Injury*

- **Manning** *Chest* 1994
  - 2 forms of VALI,
    1. barotrauma
      i. pulmonary interstitial emphysema
      ii. pneumothorax
      iii. pneumomediastinum
      iv. subcutaneous emphysema
    2. acute lung injury
      - less well described, acute injury associated with IPPV
  
  *NB:* growing evidence that *lung volume*, or more accurately *lung overdistension*, is the primary determinant of VALI

- **Airway Pressure vs Lung Volume**
  - $P_{aw}$ usually measured as ventilator generated pressure
  - pressure acting to distend alveoli → *transmural pressure* $P_{alv} - P_{pl}$
  - therefore, 2 factors influence difference between $P_{aw}$ and $P_{tm}$,
    1. non-zero flow states → $\delta(P_{aw} - P_{alv}) \propto Q.R_{aw}$
    2. alteration of $P_{pl}$ with $P_{aw}$ / lung volume
      i. pulmonary compliance
      ii. inspiratory / expiratory muscle activity
      iii. thoracic cage / abdominal compliance

- **Barotrauma**
  - multiple studies document correlation between peak $P_{aw}$ and barotrauma
  - Petersen & Baier, CCM 1983, prospective study of 171 patients,
    1. $P_{pAW} > 70$ → 10/23 43%
    2. $P_{pAW} \sim 60-70$ → 4/53 8%
    3. $P_{pAW} < 60$ → 0/95 0%
• however, conclusion that $P_{pAW}$ causes barotrauma is tenuous,

1. correlation of $P_{pAW}$ & barotrauma not always this strong
   - Leatherman, ARRD '89, 42 asthmatic patients, no barotrauma despite,
     - $P_{pAW}$’s as high as 110 cmH$_2$O
     - mean $P_{AW}$ ~ 68 cmH$_2$O

2. barotrauma well documented at low levels of $P_{pAW}$
   - Rohlfing, Rad. '76, 6/38 patients with BT had $P_{pAW} < 25$

3. ventilatory methods aimed at reducing $P_{pAW}$ of little benefit
   - Mathru, CCM '83, CMV vs IMV
     → lower incidence with IMV despite higher $P_{pAW}$
   - Clevenger, Arc. Surg. '90, converted IPPV to HFJV for "Salvage"
     → ↓ mean $P_{AW}$ from 92 to 41 cmH$_2$O,
       ↑ BT from 0/15 to 7/15 within 21 hrs of conversion
   - Tharratt, Chest '88, converted 31 pts with ARDS to PCIRV
     → ↓ mean $P_{AW}$ by 20 cmH$_2$O,
       ↑ BT from 0/31 to 8/31

4. incidence of BT also associated with $V_L$
   - Bone, ARRD '75 / '76, 2 studies looking at BT and $V_T$ in ARDS
     i. 50 patients → mean $V_T$ ~ 22 ml/kg with BT (40%)
                     mean $V_T$ ~ 17 ml/kg without BT
     ii. 106 pts → mean $V_T$ ~ 11 ml/kg with BT (3.8%)

5. "large increases in $P_{pAW}$ are often associated with large increases in $V_L$, but in most studies to date, no assessment of $V_L$ changes was made which would allow one to distinguish between the effects of high $P_{pAW}$ and those of lung overdistension", Manning
   - Williams, ARRD '92, prospective study
     22 asthmatics → risk factors for BT & CVS instability,
     "only variable predictive of BT was end-inspiratory lung volume,
     a measure of dynamic pulmonary hyperinflation"
   - two animal studies looking at BT with / without thoracoabdominal binding :

     **unbound group** → lower mean tracheal pressure
                          higher incidence of BT
Acute Lung Injury

- studies looking at ventilator induced ALI limited to animals (obviously)
- various study end-points,
  1. macroscopic lung appearance
  2. histologic lung appearance
  3. alveolar permeability
  4. microvascular permeability

**NB:** studies separating \( P_{pAW} \) and \( V_L \), i.e. bound versus unbound animals, support the concept that \( V_L \) and *not* \( P_{pAW} \) is associated with ALI

Patient Management

Low Thoraco-Abdominal Compliance

- \( P_{pl} \) should increase in proportion to mean \( P_{AW} \). . . minimal increased risk of BT
- however, situations of predominately thoracic or abdominal compliance changes may result in **regional overdistension**

High Airways Resistance

- potential problem, as \( P_{pAW} \) may not correlate with hyperinflation
- Tuxen & Lane, ARRD ’87, in severe asthmatics requiring mechanical ventilation,
  1. \( \downarrow V_T \) \( \rightarrow \) \( \downarrow \) both \( P_{pAW} \) and hyperinflation
  2. \( \downarrow \) PIFR (\( V_T \) const) \( \rightarrow \) \( \downarrow P_{pAW} \) but \( \uparrow \) hyperinflation

**NB:** "management .... should focus on providing the minimum \( V_T \) and \( V_M \) consistent with acceptable (but not necessarily normal) gas exchange, and on using a sufficiently high inspiratory flow rate to allow adequate time for exhalation"
ARDS

- Maunder, JAMA '86, ARDS affects the lung in a "patchy" fashion,
  → areas of diseased and areas of *near-normal* lung

- thus, $V_T$ will tend to be preferentially distributed to the areas of "normal" lung
- no specific ventilatory guidelines to ensure the absence of regional hyperinflation
- on the basis that static *transpulmonary pressure* $\sim 35-40$ cmH$_2$O inflates normal lung to VC, suggested peak $P_{alv} < 35-40$ cmH$_2$O
  - however,
    1. Marini, CCM '92 → $P_{pAW}$ may not correlate with peak $P_{alv}$
    2. Egan, J.App.Phys → "normal" $P_{pAW}$ tolerated by whole lung inflation may result in BT with regional inflation

- theoretical approach would be to scale $V_T$ in proportion to lung compliance
  1. ↓ normal lung → ↓ compliance → ↓ $V_T$ requirement
  2. monitor $P_{plat}$ & adjust $V_T$, but ?? at what level

Questions

1. what influence does PIFR, or more accurately $dV_L/dt$, have upon BT?
2. is patient-ventilator asynchrony a risk factor for BT?
3. what are the relative roles of mean versus peak $V_L$ on VALI?
4. what is the best approach for ventilation of ARDS patients?
5. is there a difference between PCV and SIMV, providing both focus on avoidance of lung overdistension, with respect to VALI?
6. does repetitive opening/closing of units result in higher BT?
   - ie. should we ensure $V_T$ occurs above inflexion point

ICU - Respiratory
overdistention and cyclic reopening of collapsed alveoli implicated in the lung damage found in animals submitted to artificial ventilation

- 28 patients with early ARDS were randomly assigned to
  1. new approach - end-expiratory pressures > lower inflection point of the PV curve
     - VT < 6 ml/kg, PpAW < 40 cm H2O, permissive hypercapnia
  2. conventional - volume-cycled ventilation, VT ~ 12 ml/kg
     - minimum PEEP guided by FIO2 and hemodynamics
     - 'normal' PaCO2 levels

- NA exhibiting better,
  1. evolution of the PaO2/FIO2 ratio (p < 0.0001)
  2. compliance (p = 0.0018)
  3. shorter periods under FIO2 > 50% (p = 0.001)
  4. lower FIO2 at the day of death (p = 0.0002)

**NB:** but no significant improvement in survival (5/15 vs 7/13, p = 0.45)

concluded that "the NA ventilatory strategy can markedly improve the lung function in patients with ARDS, increasing the chances of early weaning and lung recovery during mechanical ventilation"
ACUTE RESPIRATORY DISTRESS SYNDROME

- **Definition**
  - Ashbaugh et al. (Lancet 1967) described a condition in adults which was similar to the respiratory distress syndrome of infants (1 of the 12 patients was 11 yrs old)
  - The term *ARDS* was coined by Petty & Ashbaugh in 1971
  - Previously no agreed diagnostic criteria, therefore difficulty in comparing studies of incidence, mortality and treatment efficacy
  - Actually represents a subset of *acute lung injury*
  - The essential features include,
    a. *acute* respiratory failure, usually requiring mechanical ventilation
    b. *severe hypoxaemia* with a high $P_{A-aO_2}$ gradient
    c. *bilateral* diffuse infiltration on CXR
    d. stiff lungs with $C_T \leq 50 \text{ ml/cmH}_2\text{O}$
    e. pulmonary oedema should not be cardiogenic in origin, the PAOP should not be elevated, definitions $\text{PAOP} \leq 12-18 \text{ mmHg}$
    f. presence of a known *predisposing condition* - sepsis, trauma - aspiration

*NB:* Lloyd, Newman and Brigham (1984) objected to this as it precluded the diagnosis in patients with pre-existing conditions which raised LAP

- **American-European Consensus Conference**

  **Def’n:** *acute lung injury* is a *syndrome* of inflammation and increased permeability that is associated with a constellation of clinical, radiologic, and physiologic abnormalities that cannot be explained by, but may coexist with, left atrial or pulmonary capillary hypertension:
  1. timing $\rightarrow$ *acute* onset
  2. oxygenation $\rightarrow$ PaO$_2$ / F$_{I\text{O}_2}$ $\leq 300$ mmHg *irrespective* of PEEP
  3. CXR $\rightarrow$ *bilateral* infiltrates on frontal CXR
  4. PAOP $\rightarrow$ $\leq 18 \text{ mmHg}$

  **Def’n:** *acute respiratory distress syndrome*, is a subset of ALI, meeting the above criteria, where,
  1. oxygenation $\rightarrow$ PaO$_2$ / F$_{I\text{O}_2}$ $\leq 200$ mmHg

*NB:* ALI/ARDS are a *continuum* and are not specific disease entities, therefore, any cut-off limit for definition purposes is strictly *arbitrary*
studies of ARDS subgroups show that of those with \(\text{PaO}_2/\text{FiO}_2 \leq 200\), 98% progress within 1 to 7 days to a ratio < 150 mmHg. Thus, the higher figure allows earlier 'diagnosis' for study purposes, however care must be taken to exclude other causes. Mechanical ventilation was not considered a requirement for definition, as when this is instituted is very institution/clinician dependent. Chronic lung diseases such as interstitial pulmonary fibrosis, sarcoidosis etc. would meet the criteria except for chronicity, and are thus excluded from the diagnosis.

- CXR infiltrates should be bilateral, consistent with pulmonary oedema and importantly may sometimes be very mild.
- PAOP measurement is not considered essential for diagnosis, but is clearly useful.
- Diffuse pulmonary infection, if meeting the above criteria, is included in the diagnosis.
- However, this was not agreed upon by all members at the consensus.

**Diagnostic Criteria - Petty**

**NB:** included for historical comparison

1. **clinical setting**
   - catastrophic event - pulmonary or non-pulmonary
   - exclusions - chronic respiratory disease
   - LV dysfunction
   - respiratory distress - RR > 20 bpm
   - laboured breathing

2. **CXR** *diffuse / bilateral pulmonary infiltrates*
   - interstitial - early
   - alveolar - late

3. **physiology**
   - \(\text{PaO}_2 \leq 50\) mmHg * with a \(\text{FiO}_2 \geq 0.6\)
   - \(C_T \leq 50\) ml/cmH\(_2\)O * usually ~ 20-30 ml/cmH\(_2\)O
   - \(Q_s/Q_T\) increased
   - \(V_{d}/V_{T}\) increased
   - increased V/Q anomaly

4. **pathology**
   - heavy lungs - usually \(\geq 1000\) g
   - congestive atelectasis
   - hyaline membranes & fibrosis
### Lung Injury Score

<table>
<thead>
<tr>
<th>Component</th>
<th>Score Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CXR Score: alveolar consolidation</strong></td>
<td>none</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>1 quadrant</td>
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</tr>
<tr>
<td></td>
<td>2 quadrants</td>
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<tr>
<td></td>
<td>3 quadrants</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>4 quadrants</td>
<td>4</td>
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<tr>
<td><strong>Hypoxaemia Score: PaO₂/FI₂O₂</strong></td>
<td>≥ 300</td>
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<tr>
<td></td>
<td>225-299</td>
<td>1</td>
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<td>175-224</td>
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<td>100-174</td>
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<tr>
<td></td>
<td>&lt; 100</td>
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<tr>
<td><strong>PEEP Score: PEEP</strong></td>
<td>≤ 5 cmH₂O</td>
<td>0</td>
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<tr>
<td></td>
<td>6-8 cmH₂O</td>
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<tr>
<td></td>
<td>9-11 cmH₂O</td>
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<td>12-14 cmH₂O</td>
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<td></td>
<td>≥ 15 cmH₂O</td>
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<td><strong>Compliance Score: Crs</strong></td>
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</tr>
<tr>
<td></td>
<td>≤ 19 ml/cmH₂O</td>
<td>4</td>
</tr>
</tbody>
</table>

No Lung Injury | 0 |
Mild to Moderate Lung Injury | 0.1-2.5 |
**Severe Lung Injury** (ARDS) | > 2.5 |

1 Final Score = aggregate sum / number of components used

---

**Pathophysiology**

- useful to consider 2 distinct pathways,
  1. **direct** insult to lung cells
  2. **indirect** effects of systemic inflammatory response
- despite effort, **no consensus** could be reached on the order of events leading to ALI
- many believe the pathogenesis is different for various precipitating causes

---

**NB:** "current knowledge is neither sufficient to allow an intelligent conclusion about the precise sequence of events, nor sufficient to allow determination of which of these putative mechanisms are more important"  
Consensus Report, ICM 1994
### Risk Factors

<table>
<thead>
<tr>
<th>Direct injury</th>
<th>Indirect injury</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. aspiration syndromes</td>
<td>1. severe SIRS / sepsis</td>
</tr>
<tr>
<td>- acid aspiration</td>
<td>2. major non-thoracic trauma</td>
</tr>
<tr>
<td>- gastric aspiration</td>
<td>- ISS, APACHE II, TISS</td>
</tr>
<tr>
<td>- near-drowning</td>
<td>- clinical description</td>
</tr>
<tr>
<td>2. infections</td>
<td>3. shock / prolonged hypotension</td>
</tr>
<tr>
<td>- bacterial, viral, PCP</td>
<td>- reperfusion injury</td>
</tr>
<tr>
<td>3. pulmonary contusion</td>
<td>4. massive blood transfusion</td>
</tr>
<tr>
<td>4. embolic syndromes</td>
<td>5. transfusion reaction</td>
</tr>
<tr>
<td>- amniotic fluid</td>
<td>6. anaphylaxis / anaphylactoid reactions</td>
</tr>
<tr>
<td>- fat</td>
<td>7. rarely associated with</td>
</tr>
<tr>
<td>- rarely air</td>
<td>- pancreatitis</td>
</tr>
<tr>
<td>5. radiation pneumonitis</td>
<td>- DIC</td>
</tr>
<tr>
<td>6. drug toxicity</td>
<td>- cardiopulmonary bypass</td>
</tr>
<tr>
<td>- bleomycin, salicylates, opioids</td>
<td>- head injury</td>
</tr>
<tr>
<td>- paraquat, (O_2)</td>
<td>- burns</td>
</tr>
<tr>
<td>7. toxic gas / vapour inhalation</td>
<td>- diabetic coma</td>
</tr>
<tr>
<td>- (NO_2, NH_3, SO_2, Cl_2)</td>
<td>- high altitude</td>
</tr>
<tr>
<td>- industrial solvents</td>
<td>- uraemia</td>
</tr>
</tbody>
</table>

\(^1\) modified from Nunn 3\textsuperscript{rd} Ed., LIGW & Consensus Report, ICM 1994

- Pepe's group found the highest single risk factor was **sepsis syndrome**, with 38% of patients in this group developing ARDS
  1. risk factor \(\rightarrow\) \(~25\%\)
  2. risk factors \(\rightarrow\) \(~42\%\)
  3. risk factors \(\rightarrow\) \(~85\%\) risk of developing ARDS

- Fowler's group found the highest incidence in **aspiration** (35.6%) followed by DIC (22.2%) and pneumonia (11.9%)

  - the **major** predisposing factors are now agreed to be,
    1. severe sepsis - particularly gram (-)ve
    2. aspiration of gastric contents
    3. multiple trauma - particularly with pulmonary contusion
    4. massive transfusion
    5. DIC

**NB:** ICM 1994, highest incidence appears to be **septic shock** \(~25\text{-}42\%\)
it is extremely difficult, if not impossible to separate the toxic effects of a high FIO₂ from the pathological conditions requiring their use

however, it is unlikely that O₂ plays a significant role in pathogenesis

there is considerable difference in the reported incidence, probably reflecting the different diagnostic criteria in different studies

T.Oh: the true incidence is unknown and may only be ~ 7% of "at risk" patients

there is, however, good agreement on the overall mortality, which is as high as 50%

this tends to be higher in cases which follow septicaemia, being reported as

a. Fein et al. (1983) ~ 81%
b. Fowler et al. (1983) ~ 78%

multiple papers stating that mortality has remained relatively unchanged over the last 20 yrs

Milberg et al. JAMA 1995

918 patients in 5 ICU's between 1983-1993, over 18 years age

outcome measure → 30 day hospital mortality

major causes

i. sepsis syndrome ~ 37%
   ii. trauma ~ 25%

3. crude mortality rates, adjusted for age, ARDS risk, sex were unchanged

4. however, significant decrease in mortality in,

   i. sepsis related ARDS * 67% → 40%
   ii. patients < 60 years of age
Infiltrative Phase

- earliest histological lesion is interstitial & alveolar oedema ~ 24-96 hrs post-injury
- this is characterized by damage to the integrity of the blood-gas barrier, both endothelial cells and alveolar type I cells $\rightarrow$ not visible by light microscopy
- EM shows extensive damage to type I alveolar epithelial cells, which may be totally destroyed
- the BM is usually preserved and the epithelial cells form a continuous layer, with cell junctions seemingly intact
- endothelial permeability is nevertheless increased
- interstitial oedema is found predominantly on the "service" side of the capillary, sparing the "active" side
- this pattern is similar to that observed with cardiogenic oedema
- pulmonary lymph drainage is capable of increasing ~ 8x without formation of oedema
- protein containing fluid leaks into the alveoli, together with rbc's and leukocytes bound in an amorphous material containing fibrous strands $\rightarrow$ triggers replication of alveolar type II cells
- this exudate may form sheets lining alveoli $\rightarrow$ hyaline membrane
- impaired surfactant production results from either alveolar epithelial injury or secondarily from the effects of therapy (IPPV / O$_2$)
- intravascular coagulation is common at this stage
- in patients with septicaemia, capillaries may be completely plugged with leukocytes and the underlying endothelium damaged

Proliferation Phase

- cellular proliferation starts within 3-7 days of injury
- there is thickening of the endothelium, epithelium and interstitial space
- there is less oedema, but the spaces are filled with rbc's and inflammatory cells
- type I epithelial cells are destroyed and replaced by type II epithelial cells which proliferate but do not differentiate immediately to type I cells
- they remain cuboidal and ~ 10 times the thickness of normal type I cells
- this appears to be a non-specific response, as it also occurs in oxygen toxicity
- characterized clinically by worsening hypoxaemia and development of pulmonary hypertension
- pulmonary hypertension results from,
  a. vascular microthrombi
  b. platelet aggregation & release of vasoactive mediators
  c. impaired endothelial synthesis of nitric oxide

- fibrosis commences after 7-10 days and ultimately fibrocytes predominate
- extensive fibrosis is seen in resolving cases
- within the alveoli, the protein rich exudate may organise to produce the characteristic 'hyaline membrane', which effectively destroys alveoli
Mechanisms of Causation

- due to the diverse aetiology several mechanisms of causation, at least in the early stages
- in all cases, initiation seems to occur following damage to the alveolar/capillary membrane with transudation often increased by pulmonary venoconstriction
- thereafter, the condition is accelerated by a number of positive feedback mechanisms
- the initial insult may be either direct or indirect (see table above)
- much of the interest is in the indirect causes, which may be mediated either by cellular or humoral elements
- **cell types** capable of damaging the membrane include,
  - a. neutrophils
  - b. basophils
  - c. macrophages
  - d. platelets - through arachidonic acid derivatives

- **humoral agents** include,
  - a. bacterial endotoxin
  - b. \(O_2\) free radicals
  - c. proteases
  - d. thrombin, fibrin and FDP's
  - e. histamine, bradykinin, and serotonin
  - f. platelet activating factor (PAF)
  - g. arachidonic acid metabolites

- various chemotactic agents, especially \(C_5a\), play a major role in the direction of formed elements onto the pulmonary endothelium
- Malik, Selig and Burhop (1985) drew attention to the fact that many of the humoral agents are capable of producing **pulmonary venoconstriction**
- this facilitates transudation caused from increased permeability
- Seeger et al. noted that a number of proteins, including albumin but particularly **fibrin monomer**, antagonize the effects of surfactant

**T.Oh:** two possible mechanisms of causation,

1. \(C'\) activation
2. fibrinolysis and platelet activation

**NB:** however, both suffer from sparse clinical evidence,
\(C'\) has no predictive value and is non-specific
FDP-D 'antigen' identified in patients with ARDS and may be a marker of mediator injury
Neutrophil Mediated Injury

• the postulated sequence begins with activation of C5a, which results in marginalization of neutrophils on vascular endothelium
• this is known to be activated in sepsis and during cardiopulmonary bypass
• significant margination is seen in many cases of ARDS
• however, margination can occur without significant lung injury, as occurs during haemodialysis with a cellophane membrane
• the postulate is that the neutrophils are somehow primed prior to margination
• this may occur with endotoxin, which results in firm adherence of neutrophils to the endothelium
• C5a results in temporary adherence but more importantly triggers inappropriate release of lysosomal contents to the cell exterior, cf. into phagocytic vesicles
• four groups of substances released in this way may potentially damage the endothelium;
  1. O2 derived free radicals → lipid peroxidation
     inactivate α1-antitrypsin
  2. proteolytic enzymes (esp. elastase) → direct endothelial damage
     monocyte/macrophage chemotaxis
     (elastin fragments)
  3. arachidonic acid metabolites → vasoconstriction
     increased permeability
     neutrophil chemotaxis
  4. platelet activating factors → intravascular coagulation
     direct tissue damage

• the role of neutrophils has been studied in depleted animals with conflicting results
• ARDS does seem less severe in neutropaenic patients, however it still may develop
• while they possess the capability for tissue damage, it seems unlikely they are the sole agent

Macrophages & Basophils

• these have been studied to a far lesser extent
• they contain a similar array of potentially tissue destructive factors and are already present within the alveoli
• there numbers are greatly increased in patients with ARDS

Platelets

• these are also present in large numbers in the capillaries of patients with ARDS
• aggregation at that site is associated with an increase in capillary hydrostatic pressure, possibly due to a release of arachidonic acid metabolites
• they may also play a role in the normal integrity of the capillary endothelium (Malik, Selig & Burhop, 1985)
**Mediators**

a. **prostaglandins**
   - TXA$_2$
   - PGI$_2$

b. **leukotrienes**
   - chemotaxis
   - vasoconstriction
   - bronchoconstriction

c. **lymphokines**
   i. IL-1 & TNF
      - widespread immune stimulation
      - activation of inflammatory response
      - septic syndrome, fever
      - vasodilatation
      - hyperdynamic circulation
      - systemic catabolism, hepatic anabolism
      - acute phase response
   ii. IL-1 & 2
      - T-cell stimulation/activation
   iii. IL-3 & CSF's
      - marrow & specific colony stimulation
   iv. IL-4 & 6
      - B-cell stimulation
   v. interferons
      - antiviral activity
      - T & NK cell stimulation

   • IL-1, or *endogenous pyrogen*, acts on the pre-optic area of the hypothalamus with subsequent heat production

d. **complement**
   - chemotaxis
   - vasodilatation
   - increased capillary permeability

e. **others**
   i. endotoxin
   ii. kallikrien / kinin system
   iii. histamine
   iv. serotonin
   v. FDP's
Lung Mechanics

- lung compliance \( C_L \) is reduced (< 40 ml/cmH\(_2\)O) and is adequately explained by histology
- there is impaired production of surfactant (Fein et al. 1982)
- Petty (1979) using BAL showed abnormally aggregated and inactive surfactant
- FRC is reduced below CC by collapse, tissue proliferation and increased elastic recoil
- alveolar/capillary permeability is increased as demonstrated by studies of transit times with inert tracer molecules
- the concept of "non-cardiogenic" capillary leak is oversimplified, possibilities being,
  a. \( C' \) activation
  b. fibrinolysis and platelet activation

- Dankzer et al. (1979) found a bimodal distribution of perfusion → one range of near normal V/Q ratios, the other to areas of near zero V/Q
- this was sufficient to explain the \( P_{A-aO_2} \) gradient without the need to evoke changes in the diffusing capacity \( DC_{O_2} \)
- physiological shunt \( Q_S \) is usually so large (~ 40%) that a near normal \( P_{aO_2} \) cannot be achieved even with a \( FIO_2 = 1.0 \)
- the increase in \( V_D \), which may exceed 70%, would require a large \( V_M \) to preserve normocapnia
- it may be argued that attempting normocapnia in these patients is inappropriate management
- gaseous exchange is further impaired, in that \( VO_2 \) is usually increased, despite the patient being paralysed and artificially ventilated (Sibbald & Dredger, 1983)

- **Changes in Respiratory Mechanics** (Start in Phase 1)
  a. ↓ total pulmonary compliance
  b. ↓ FRC
  c. ↑ airways resistance
  d. ↑ work of breathing
  e. ↑ respiratory rate & decreased \( V_T \)

- **Changes in Haemodynamics** (Sibbald, 1983)
  a. ↑ \( P_{PAW} \) - ↑ RV afterload
  - ↑ RVEDV & RVEDP
  - ↓ RVEF \( \propto 1/(\text{mean } P_{AW}) \)
  - ↓ RV contractility
  b. normal LV function early
  c. ↑ PAOP, without ↑ LVEDV → ? ventricular interdependence / ? ↓ LV compliance
  d. LV dysfunction in later stages
Principals of Management

**NB:** → treatment of **primary cause**, 
other management is essentially supportive

- no specific therapeutic measure has been shown to significantly reduce the development / progression of the disease
- there are four main objectives of management (Nunn)
  1. maintenance of an adequate $P_{aO2}$
  2. minimize pulmonary transudation
  3. maintenance of an adequate circulation
  4. prevent complications, particularly *sepsis*

- **T.E. Oh**
  1. ventilation - PEEP, CPAP, PCV, IRV
     - permissive hypercapnoea, "open-lung" models
  2. fluid management
  3. cardiac support
  4. nutrition
  5. physiotherapy
  6. other therapies
     i. antibiotics *(only by M,C&S, not prophylactic)*
     ii. steroids - late fibroproliferative phase, in absence of infection
     iii. heparinisation - not useful for ARDS
     iv. ECMO
     v. ultrafiltration - patients unresponsive to diuretics with H$_2$O retention
        ? clearance of mediators of sepsis, medium MW

- **Concensus Conference ICM 1994**
  - several therapeutic methods are so universally accepted that, although not formally tested, may be considered as standard,
    1. supplemental $O_2$
    2. PEEP / CPAP
    3. mechanical ventilation
    4. avoidance of fluid overload
    5. delivery of care in an ICU setting
- **Ventilation**

  - ventilation should be adjusted to maintain adequacy of oxygenation and to reduce peak and mean airway pressure
  - PEEP is almost universally required to maintain an adequate $P_{aO_2}$
  - it is of no prophylactic benefit but *does* improve survival
  - benefits of PEEP are,
    a. reduction in $F_iO_2$
    b. improved $DO_2$
    c. increased compliance
    d. reduction in atelectasis

  - hazards of PEEP include,
    a. *increase* in total lung water
    b. inactivation / destruction of surfactant
    c. may produce a fall in CO and $DO_2$

  - normocapnia becomes a lower priority as *barotrauma* becomes more likely
  - HFJV & HFPPV provide no advantage over traditional ventilation
  - they do result in a decrease in mean $P_{IP}$, but there is no improvement in mortality
  - ECMO has shown *no proven* benefit, mortality remains the same
  - Morris *et al.* (AJRCCM ’94) "Salt Lake City Trial", comparing,
    1. computer driven models of ventilation with SIMV
    2. PCIRV & EC-CO$_2$R

    **NB:** maintaining similar mean $P_{AW} \rightarrow$ *no benefit* in mortality

  - Lessard *et al.* (Anaesth. ’94) showed *no benefit* in terms of barotrauma, oxygenation, or survival with the use of PCIRV versus conventional ventilation when efforts to keep total PEEP and *mean airway pressure* the same were made

  - the level of *optimal PEEP* is described using various end-points,
    1. maximal $DO_2$
    2. lowest $Q_S$ < 15%
    3. $P_{aO_2} > 60$ mmHg *with lowest $F_iO_2 \geq 30%$
    4. maximal improvement in $C_L$
       i. dynamic V/P curves
          - maximal volume recruitment for given $P_{AW}$ *above inflexion point
       ii. static V/P curves
          - inflexion point with recruitment
**Pharmacotherapy**

- fluid balance should be adjusted to lessen the formation of oedema
- Fein *et al.* recommend values of PAOP ~ 5-10 mmHg
- administration of NSA-C / 5% does not reduce the formation of oedema
- some early work suggested the administration of massive doses of steroids may halt the development of the disease, Sibbald *et al.* 1981
- subsequent work has shown no benefit, or an increased incidence of sepsis and a higher mortality, thus the administration of steroids is not recommended for routine cases
- Meduri *et al.* (Chest '94) showed steroids may be of benefit for the subgroup of *late proliferative ARDS* providing underlying infection was meticulously ruled-out,
  1. blood cultures, CUD urine specimen
  2. BAL + quantitative culture, or PSB
  3. no other septic foci - lines, GIT
- other pharmacotherapy includes,
  1. endotoxin Ab's - anti-LPS Ab
  2. free radical scavengers - antioxidants, SOD, catalase, NAC
  3. cyclo-oxygenase inhibitors - Indomethacin, Ibuprofen
  4. thromboxane inhibition - ketoconazole
  5. cytokine inhibition - anti-TNF
  6. surfactant replacement
  7. PGE₁

*NB:* these are only of prophylactic benefit in animal studies, none has been shown to improve outcome in human studies, Ibuprofen improves early *haemodynamic stability* but not mortality

**Outcome**

a. mortality ~ 50-70%
   - unchanged over last decade
   - ? small decrease depending upon criteria for diagnosis
b. poor prognosis - elderly
   - severe disease, uncontrolled 1° cause
   - high PVR, RV dysfunction
   - impaired DO₂
c. associated problems
   i. *nosocomial pneumonia* ~ 70%
   ii. high incidence of sepsis syndrome
   iii. MODS
Fluid Management in ARDS / Pulmonary oedema

- **Simmons et al.,** *ARRD Apr-1987*
  - effect of fluid balance on survival in ARDS
  - 213 patients in a prospective data collection study → 113 met criteria for ARDS
  - multiple variables up to 14 days after intubation → CO, PAOP, MAP, I-O, ΣI-O, δWt
  - significant differences in ΣI-O and δWt between survivors and nonsurvivors on almost every day → survivors lost weight and significantly lower ΣI-O cf. nonsurvivors
  - logistic regression to determine if δWt and ΣI-O could predict survival,
    - ↓ wt. ≥ 3 kg → 67% survival
    - ↑ wt. ≥ 3 kg → 0% survival day 14
  - similar results obtained using comparably low and high values for ΣI-O

  **NB:** this does not establish a cause and effect relationship,
  likely means only that "sicker" patients needed more fluid resuscitation & developed "leakier" capillaries

- **Humphrey et al.,** *Chest. May-1990*
  - looked at survival and ICU length of stay of 40 ARDS patients
  - analyzed to determine if a management strategy of lowering the PAOP was associated with an increased survival or a decreased ICU length of stay
  - patients were divided into two groups:
    1. group 1 - reduction of PAOP ≥ 25%
    2. group 2 - reduction of PAOP ≤ 25%
  - survival to hospital discharge
    1. group 1 - 12/16 75%
    2. group 2 - 7/24 29%
  - difference remained statistically significant stratifying patients by age & APACHE II

  **NB:** concluded that, "analysis supported the notion that treatment of low pressure pulmonary edema with reduction of PAOP is associated with an increased survival"

  similarly, this does not imply a causal relationship for therapy,
  patients in whom greater reductions in PAOP can be achieved are likely less severe and more likely to survive anyway
Eisenberg et al. ARRD Sep-1987

- prospective evaluation of extravascular lung water (EVLW) instead of pulmonary artery wedge pressure measurements to guide the hemodynamic management of 48 critically ill patients
- randomized → protocol management, PM
  → routine management, RM groups
- RM group → EVLW measurements blinded
- groups similar for age, gender, and severity of illness
- of patients with initially high EVLW → EVLW decreased
  → PM ~ 18 ± 5%
  → RM ~ 4 ± 8% (p < 0.05)
- difference was greater in patients with CCF
- following the protocol, no adverse effects on - oxygenation - renal function

- mortality →
  1. not statistically different for entire groups
  2. significantly better (p < 0.05) for PM patients with initially high EVLW and normal PAOP (predominantly sepsis or ARDS patients)

- mortality for both groups of patients,
  1. initial EVLW > 14 ml/kg → 13/15 87%
  2. initial EVLW < 14 ml/kg → 13/32 41% (p < 0.05)

NB: concluded that, "management based on a protocol using EVLW measurements is safe, may hasten the resolution of pulmonary edema, and may lead to improved outcome in some critically ill patients"
**Mitchell, Schuller, et al. ARRD 1992**

- randomised prospective trial to assess effect of management emphasising diuresis & fluid restriction on,
  1. development or resolution of EVLW
  2. mechanical ventilation hours
  3. ICU duration

- 101 patients requiring PAC insertion,
  1. 52 patients → EVLW management
  2. 49 patients → PAOP management

- 89 patients with pulmonary oedema = EVLW > 7 ml/kg (ideal BW)
- no significant differences in baseline disease status (APACHE II, OSF), minor age difference

<table>
<thead>
<tr>
<th>EVLW&lt;sub&gt;t&lt;/sub&gt; : EVLW&lt;sub&gt;t=0&lt;/sub&gt;</th>
<th>PAOP Group</th>
<th>EVLW Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumulative I-O&lt;sup&gt;2&lt;/sup&gt;</td>
<td>No change</td>
<td>↓ t &gt; 24 hrs (p &lt; 0.05)</td>
</tr>
<tr>
<td>2239 ± 3695 ml</td>
<td></td>
<td>142 ± 3632 ml</td>
</tr>
<tr>
<td>median = 1600 ml</td>
<td></td>
<td>median = 754 ml</td>
</tr>
<tr>
<td>Median ICU Days&lt;sup&gt;3&lt;/sup&gt;</td>
<td>16 days</td>
<td>7 days (p = 0.05)</td>
</tr>
<tr>
<td>Median MV</td>
<td>22 days</td>
<td>9 days (p = 0.047)</td>
</tr>
<tr>
<td>↑Creatinine&lt;sup&gt;4&lt;/sup&gt;</td>
<td>17.6 ± 79 µmol/l</td>
<td>35 ± 88 µmol/l</td>
</tr>
<tr>
<td>↑BUN</td>
<td>2.1 ± 6.4 mmol/l</td>
<td>4.6 ± 9.6 mmol/l</td>
</tr>
<tr>
<td>Mortality&lt;sup&gt;5&lt;/sup&gt;</td>
<td>47%</td>
<td>35% (p = 0.21)</td>
</tr>
</tbody>
</table>

<sup>1</sup> only for the 89 patients with initial EVLW > 7 ml/kg

<sup>2</sup> *No difference* in - the number of patients requiring vasopressors/inotropes - the duration of use of vasopressors/inotropes

<sup>3</sup> *No difference* in MV or ICU duration for the subset of patients with CCF / volume overload

<sup>4</sup> Small but statistically significant increase in plasma creatinine & BUN in EVLW group

<sup>5</sup> ICU plus within 48 hours of discharge if related to ICU admission pathology

- aim to evaluate fluid balance and changes in extravascular lung water (EVLW) on survival in the ICU and short-term outcome in patients with pulmonary edema
- retrospective analysis of data, sorting by survival and "treatment received"
- taken from a randomized controlled trial of fluid restriction (Mitchell et al., ARRD 1991)
- 89 patients requiring PA catheterization with high EVLW > 7 ml/kg,

1. survival
   - survivors had no significant fluid gain or change in EVLW but decreased wedge pressure and body weight, cf. nonsurvivors

2. fluid balance
   - < 1000 ml fluid gain at 36 hrs → survival ~ 74 %
   - > 1000 ml fluid gain at 36 hrs → survival ~ 50 % (p < 0.05)

3. median ventilation days
   ICU days
   hospital days → ~ 50% for < 1000 ml fluid gain

NB: accounting for differences in the severity of illness, fluid balance was an independent predictor of survival (p < 0.05)

NB: "These data support the concept that positive fluid balance per se is at least partially responsible for poor outcome in patients with pulmonary edema and defend the strategy of attempting to achieve a negative fluid balance if tolerated hemodynamically."
ASPIRATION SYNDROMES

- there is a spectrum of presentations,
  a. **acute massive aspiration**
     i. acid aspiration pneumonitis - Mendelsonn's syndrome
     ii. non-acid aspiration
        • particulate - food, FB, non-acid vomitus
        • non-particulate - blood, water, near drowning
  b. **sub-acute aspiration**
     - microaspiration
     - nosocomial pneumonia
  c. **chronic aspiration**
     - nosocomial pneumonia
     - bronchopneumonia
     - bronchiectasis
     - lung abscess
     - ch. interstitial fibrosis
     - atypical mycobacterial fibrosis
     - late onset "asthma"

### Acute Acid Aspiration
1. acute pulmonary oedema
2. ARDS
3. acute "asthma"
4. "atypical pneumonia"
5. acute bronchopneumonia

- often previously healthy person & rapid in onset, frequently preventable
- frequently **non-infected** acid aspirate
- antacids often useful

### Chronic Micro-Aspiration
1. nosocomial pneumonia
2. recurrent bronchopneumonia
3. chronic "asthma"

- frequently in hospitalised patients and insidious in onset
- multiple risk factors and difficult to prevent
- the aspirate is frequently infected
- **antacids** may actually predispose → GIT colonisation
- ?? recent studies would **not** support his concept
- **Risk Factors**

  a. altered *conscious state*  
     - trauma  
     - coma  
     - ETOH, drugs (CNS depressants)  
     - CVA  
     - epilepsy  
     - hypotension  

  b. impaired *airway reflexes*  
     - drugs (CNS, NMJ)  
     - intubation / extubation  
     - tracheostomy  
     - CVA  
     - motor neurone disease, MS, GBS, CIP  
     - elderly  

  c. *regurgitation*  
     - pregnancy  
     - hiatus hernia  
     - obesity  
     - bowel obstruction  
     - NG tube  
     - oesophageal disease  
     - LOS dysfunction  

- **Nature of Aspirate**

  1. gastric acid  
  2. particulate  
  3. infected fluid  
  4. blood  
  5. fresh vs. salt water
**Infected Aspiration**

- differences for micro vs. macro-aspiration
- frequent colonization of the upper airways of hospitalized and critically-ill patients,

a. **pre-hospitalized aspiration**
   - predominantly anaerobes
     - Bacteroides m. & f.
     - Fusobacterium
     - Peptostreptococcus
   & some aerobes
     - Pneumococcus
     - Micrococcus

\[ R_X \] Penicillin & Metronidazole

b. **hospitalized patient + antacids**
   - predominantly gram (-)'s
     - E. coli
     - Klebsiella
     - Proteus
     - Pseudomonas
   & some gram (+)'s
     - Staphlococcus
   some fungi
     - Candida

\[ R_X \] Flucloxacillin & Gentamicin, or
   Cefotaxime + Flucloxacillin ± Metronidazole

**Treatment**

1. prevention
   - sucralfate, antacids
   - topical antibiotics
   - cricoid pressure
2. protection of airway
   - ETT
3. tracheobronchial toilet
   - suction, lavage
   - flexible/rigid bronchoscopy
4. oxygen & ventilatory support
5. chest physiotherapy
6. bronchodilator therapy
7. antibiotics
   - no proven benefit or harm
   - most would treat as above
8. steroids
   - no proven benefit or harm
   - may increase 2° infections
9. systemic support for ARDS, sepsis syndrome etc.
ACUTE ASTHMA

**Def’n:** a disease characterized by wheezing, dyspnoea and cough, resulting from *airways hyperreactivity*, and variable degrees of *reversible airways obstruction* (ATS, 1987)

- current emphasis is on airway *inflammation* in pathogenesis, in conjunction with smooth muscle mediated bronchoconstriction and intraluminal mucus
- a subgroup suffer sudden, unexpected increases in airflow obstruction, due mainly to bronchospasm, termed variously as,
  a. *sudden asphyxic asthma* - Wasserfallen, ARRD 1990
  b. hyperacute asthma - ? Tuxen

- characterized by,
  1. minimal baseline airflow obstruction, but marked hyperreactivity
  2. innocuous or unrecognized stimulus
  3. very rapid severe onset, often fatal within 1 hr
  4. relatively rapid resolution
  5. comprise ~ 75% of ventilated asthmatics

- this contrasts *acute severe asthma*, characterized by,
  1. persistent significant airflow obstruction → $\text{FEV}_1 < 50\%$ pred.
  2. relatively asymptomatic, with *underperception* of disease
  3. behaviour modification & denial
  4. attacks result from small deteriorations in function → 'apparent' sudden severe symptoms
  5. slow resolution, with large chronic component
  6. comprise ~ 25% of ventilated asthmatics

- studies of patients dying from SAA, cf. patients with chronic asthma, show,
  a. ↑ *neutrophils* / ↓ eosinophils in airways submucosa
  b. less intraluminal mucus

- Kikuchi, *et al.*, NEJM 1994, found patients with a history of *near-fatal* asthma have,
  a. a blunted hypoxic ventilatory response, and
  b. diminished dyspnoea during inspiratory resistive loading, cf. other asthmatics

**NB:** diminished *patient perception* increases the risk of future life-threatening or fatal asthma
Assessment of Severity

**NB:** no single clinical measurement has been shown to reliably predict outcome

<table>
<thead>
<tr>
<th>Mild / Moderate¹</th>
<th>Indications for IPPV</th>
</tr>
</thead>
<tbody>
<tr>
<td>• loudness of wheeze²</td>
<td>• conscious state = most useful</td>
</tr>
<tr>
<td>• forced expiratory time</td>
<td>• inability to speak</td>
</tr>
<tr>
<td>• respiratory rate &gt; 30</td>
<td>• pulsus paradoxus³ &gt; 15 mmHg</td>
</tr>
<tr>
<td>• HR &gt; 130 bpm</td>
<td>• respiratory fatigue</td>
</tr>
<tr>
<td>• use of accessory muscles³</td>
<td>• PaCO₂ ≥ normal, or rising⁴</td>
</tr>
<tr>
<td>• PEFR &lt; 30% pred.</td>
<td>• failure to respond to therapy</td>
</tr>
<tr>
<td>• FEV₁₀ &lt; 30% pred.</td>
<td></td>
</tr>
</tbody>
</table>

¹ generally not useful in severe failure
² poor correlation with degree of airflow limitation, Shim. et al., Arch.Int.Med.1983
³ may actually decrease with the onset of severe respiratory failure
⁴ hypercapnoea usually only occurs with a FEV₁ < 25%, but alone doesn't mandate IPPV; absence of hypercapnoea does not exclude severe obstruction & impending arrest

---

### ICU Admission

1. patients requiring IPPV
2. severe airflow obstruction
   i. accessory mm., exhaustion, diaphoresis
   ii. p.paradox > 12 mmHg
   iii. PEFR < 25%
3. poor response to initial therapy / deteriorate despite therapy
4. altered mental status
5. cardiac toxicity / complication
Assessment During Ventilation

a. expiratory time
b. pulsus paradoxus
c. autoPEEP
   i. static - end-expiratory occlusion pressure
   ii. dynamic - $\delta P_{IP}$ prior to onset of airflow
d. alteration in $P_{aCO2}$
e. pressure differential
   i. end-inspiratory occlusion $P - P_{IP}$
   ii. peak-to-plateau gradient $\sim 0.5$-0.75s inspiratory pause
      • $\delta P / PIFR \rightarrow$ resistance
      • but, with severe airflow obstruction 0.75s is inadequate for equilibration
f. end-expiratory trapped gas volume
   $= \text{volume expired after prolonged expiration (} \geq 1')$
g. ECG - RAD, RVH & 'strain', acute TR
h. CXR - limited use, see over

Indications for CXR

1. any asthmatic post-intubation
2. signs / symptoms of barotrauma
3. clinical findings suggestive of pneumonia
   localizing signs on chest examination
4. when the diagnosis is uncertain $\rightarrow$ exclusion

NB: Zieverink, Rad. 1982, 528 CXR’s in 122 asthmatics
   $\rightarrow$ abnormalities in $\sim 2.2\%$

Factors to Exclude

a. pneumothorax
b. FB
c. upper airway obstruction
d. LVF & severe emphysema $\pm$ echocardiogram
e. pulmonary emboli $\pm$ lower limb doppler, lung perfusion scan
ICU  Respiratory

- **Investigations**
  a. FBE, MBA
  b. serial AGA's
  c. CXR
  d. ECG
  e. microbiology - tracheal aspirate for MC&S
     - blood cultures if febrile
  f. paired serology - atypical pneumonia
  g. PFT's during recovery - serial PEFR
     - FEV₁/FVC

- **CVS Effects of Severe Asthma**
  1. pulmonary hypertension- HPV, 2° mediator release
     - acute ↑ RV afterload
     ± ↓ LV preload ∝ interdependence
  2. impaired venous return
  3. ↑ LV afterload - SNS outflow
  4. 2° effects from - hypoxia, hypercarbia & acidosis
  5. 2° effects from drugs - β-agonists, aminophylline

- **Mechanical Abnormality**
  → increased *airways resistance*
  a. all airways involved but to differing degrees
  b. regional variation in *time constants*
  c. hyperinflation and obstruction
  d. rapid shallow respiration
  e. ↑ *work* of breathing

- **Pathology**
  a. smooth muscle contraction
  b. inflammatory infiltrate & mucosal oedema
  c. mucus plugging & inspissation of secretions
  d. segmental/lobar obstruction or collapse
  e. barotrauma
Mediators

a. histamine
b. leukotrienes *LT-D₄

c. cholinergic nervous system
d. neuropeptides from NANC nervous supply
e. PG's
f. IgE
g. PAF

Complications

a. hypoxia, hypotension - myocardial, cerebral hypoxic damage
b. respiratory
   i. barotrauma / volutrauma - pneumothorax, pneumomediastinum
   ii. mucus plugging, airway obstruction, atelectasis
   iii. infection
   iv. respiratory arrest

c. biochemical disturbances
   i. hypokalaemia, hypophosphatemia, hypomagnesaemia
   ii. hyperglycaemia
   iii. lactic acidosis - hypoxia / hypotension *β-agonists, aminophylline

d. drug related
   i. theophylline toxicity
   ii. neuropathy / myopathy ? neuromuscular blockade & steroids

Long-Term Beta-2-Agonists

1. heavy use (> 1 cannister/month) is a marker of severe asthma
2. heavy or increased use warrants additional therapy with steroids
3. use may make asthma worse
4. patients currently using β₂-agonists should slowly withdraw non-essential doses & use as rescue medication during "breakthrough" asthma

NB: position statement, American Academy of Allergy & Immunology, 1993
Treatment

**Medical Treatment**

a. O\textsubscript{2} therapy

b. inhaled β\textsubscript{2}-agonists - continuous nebulized salbutamol
   - in non-intubated patients MDI's + spacing devices are equally effective as nebulizers
   - ~ 3\% of radioactive aerosol delivered by small volume nebulizer reaches the lungs in mechanically ventilated patients
   - ~ 3\% radioactive aerosol delivered by small volume nebulizer reaches the lungs in mechanically ventilated patients (MacIntyre, CCM 1985)

c. IV β\textsubscript{2}-agonists
   - no proven advantage for - IV cf. inhaled route
     - selective agents cf. adrenaline
   - result in hypokalaemia & tachyarrhythmias
   - increase the VO\textsubscript{2}, P\textsubscript{aCO\textsubscript{2}} and lactic acidosis
   - use in younger patients (preferably < 40) not responding to inhaled Rx

d. aminophylline ~ 6 mg/kg/30 mins IV
   - ~ 0.5 mg/kg/hr maintenance
   - inferior to β\textsubscript{2}-agonists as monotherapy
   - various studies have demonstrated addition of theophylline does not confer therapeutic benefit and increases tremor, N&V, arrhythmias, etc.
   - other studies show opposite, AJRCCM '95
     "inadequate evidence to support or reject the use of theophylline in this setting"
   - use in patients with poor or incomplete response to β\textsubscript{2}-agonists/steroids
   - NB: ↓ clearance ∝ CCF, liver failure, macrolides, ciprofloxacin

e. ipratropium
   - conflicting evidence but probably an additive effect, not first line agent

f. steroids
   - not useful via the nebulized route in the acute attack
   - early IV administration useful, significant difference at 12 hours
   - reduce the need/duration of hospitalisation & number of relapses
   - "failure to treat with steroids contributes to asthma deaths" AJRCCM '95

g. others
   i. MgSO\textsubscript{4} infusion
      - benefit has been described in patients with normal plasma Mg\textsuperscript{++} levels
      - ~ 50\% of patients with SA have low plasma levels
      - the 2 largest PRCT's failed to show any benefit
      - "available data do not support the use of magnesium in SA" AJRCCM '95
   ii. nitric oxide
   iii. heliox
   iv. ECMO
- **Effects of Steroids**
  1. anti-inflammatory
  2. potentiate the effects of β-agonists
  3. receptor upgrading
  4. stabilisation of lysosomal membranes
  5. reduce capillary permeability
  6. inhibit histamine release

- **Indications for Antibiotics**
  1. fever & sputum containing polymorphs/bacteria
  2. clinical findings of pneumonia
  3. signs & symptoms of acute sinusitis

  **NB:** majority are *viral* & there is no role for routine use

- **Bronchioalveolar Lavage**
  - autopsy studies show marked mucus impaction of both large and small airways
  - **no benefit** in SA has been demonstrated for chest physiotherapy, mucolytics or expectorants
  - in intubated patients, potential risk of an acute increase in $V_{EI}$ due to increased resistance

  **NB:** "*should not be considered a part of routine management of ventilated asthmatics*"

- **CPAP Ventilation**
  a. potential advantages
    i. ↓ work of breathing
    ii. ↓ inspiratory muscle load & ↑ muscle efficiency
    iii. ↓ need for sedation / anaesthesia / intubation
    iv. ? ↓ incidence of  - nosocomial pneumonia
         - otitis & sinusitis
  b. potential disadvantages
    i. gastric distension & risk of aspiration
    ii. less control over ventilatory pattern
    iii. exacerbation of gas-trapping & overexpansion
    iv. pressure necrosis

  **NB:** "*further studies involving large numbers of patients are needed*"
### Paralysis

1. potential advantages
   i. ↓ VO$_2$ & CO$_2$ production
   ii. ↓ lactate production
   iii. *may* decrease risks of barotrauma *theoretical, not proven*
   iv. ↓ expiratory muscle activity may ↓ airways resistance

2. potential disadvantages
   i. difficulty assessing mental status / risks of awareness
   ii. ↑ risk of DVT
   iii. disuse muscle atrophy
   iv. ? causative role in myopathy in acute asthmatics with steroids
      - other possible factors include hypokalaemia, hypophosphataemia & high dose beta-agonists
      - the contention that the steroid molecule of vecuronium/pancuronium would potentiate this effect is *not supported* Fleugel, AJRCCM 1994

*NB:* concensus view, "until further data available, NMJ blockade should be reserved for patients unable to be ventilated with sedation alone"

### Ventilatory Parameters

- $V_T \leq 10$ ml/kg
- rate $\leq 10$ bpm
- high flow rate $\geq 80$ l/min
- high $F_{I}\text{O}_2 \geq 0.5$

a. $F_{I}\text{O}_2 \rightarrow$ adequate to prevent hypoxia
b. $V_T \rightarrow$ limits peak $P_{AW} \leq 50$ cmH$_2$O (*not necessarily*)
c. rate $\rightarrow$ allows full expiration - ie. minimal auto-PEEP
d. pulse paradox $\leq 30$ mmHg
e. end-expiratory $P_{OCC} \leq 10$ mmHg
   - measures of autoPEEP are only accurate in paralysed patients
   - has not been shown to correlate with complications
   - may significantly underestimate hyperinflation due to noncommunicating gas
f. end-inspiratory volume $< 20$ ml/kg
   - $V_{EI} > 20$ ml/kg $\rightarrow$ ↑ barotrauma, hypotension (Tuxen *et al.*, ARRD'92)
   - however, not prospectively validated & doesn't measure all trapped gas
g. end-inspiratory $P_{Plat} < 25$ mmHg (30 cmH$_2$O)
   - more easily determined than $V_{EI}$ but not a reliable predictor of complications
   - like $V_{EI}$, not prospectively validated, but complications rare at $P_{Plat} < 30$ cmH$_2$O
   - this equates to ~ 1.6 l increase above FRC
Risks of Permissive Hypercapnia

1. cerebral vasodilatation
2. cerebral oedema
3. decreased myocardial contractility
4. systemic vasodilation & hyperdynamic circulation
5. pulmonary vasoconstriction

NB: most of these are not significant for otherwise healthy patients, hypoventilation is well tolerated with $P_{aCO}_2 < 90 \text{ mmHg}$ (Darioli, ARRD 1984)

- virtually all studies of permissive hypercapnia in SA report near-zero mortality rates, significantly less than studies where 'normal' AGA values are achieved, though there is no large RCT

Prevention of Further Episodes

1. education - disease and drug administration
2. monitoring using a peak flow meter
3. regular anti-inflammatory therapy
   - use of a spacing device & mouth washing post-inhalation
4. rescue use of $\beta$-agonists
5. early presentation for medical assessment with deterioration

Causes of Death

NB: a history of near-fatal asthma requiring mechanical ventilation is the single best predictor of subsequent asthma death

1. cerebral hypoxia
2. barotrauma
3. tension pneumothorax
ATYPICAL PNEUMONIA SYNDROME

**Common Causes**

1. viral pneumonia - influenza A&B, parainfluenza - RSV, CMV, varicella
2. *Mycoplasma pneumoniae* ~ 5% community acquired
3. *Legionella pneumophilia* ~ 3% community acquired • probably underdiagnosed to a significant degree
4. *Chlamydia psittaci* pneumoniae
5. *Coxiella burnetti* * Q fever
6. atypical mycobacteria

**Other Causes**

1. infective
   i. atypical presentation of bacterial pneumonia
   ii. pulmonary TB
   iii. opportunistic infections in immunocompromised
2. non-infective
   i. thromboembolic disease
   ii. collagen vascular disorders
   iii. malignancies
3. aspiration pneumonitis

**Slowly Resolving Pneumonia**

a. **organism causes** - antibiotic resistance *ESBL producers*
   - viral, fungal, parasitic
   - superinfection
b. **therapeutic causes** - inappropriate agent / dosage
c. **host causes**
   i. lung disease - bronchiectasis, empyema, lung abscess
      - bronchial obstruction
      - chronic aspiration
      - underlying malignancy
      - interstitial & other lung diseases
   ii. other host diseases - immunocompromised
      - LVF
      - malignancy, HIV
NOSOCOMIAL PNEUMONIA

- from McLaws, MJA 1988, looking at **general hospital** populations
  → nosocomial infections occur in **6-7%** of patients
- Chastre, , 15-35% of these are pneumonia with a **mortality** rate of 50-70%
- most are endogenous **gram negative** bacteria, many are **polymicrobial**
- a high proportion occur in ICU patients

- Daschner, ICM 1982, ICU patients
  → the overall **incidence** of nosocomial infections in ICU patients ~ **12-20%**
  1. UTI ~ 40%
  2. septicaemia ~ 20%
  3. pneumonia ~ 16%

  **NB:** nosocomial infections in patients with ARDS ~ **70%**

- **Aetiology**
  a. gram negative bacilli ~ **70%**
     - E. coli
     - Pseudomonas
     - Enterobacter
     - Klebsiella
  b. gram positive cocci ~ **15-25%**
     - Staphlococci
     - Enterococcus
  c. fungal ~ **5%**
     - Candida

- **Mortality**
  a. gram negatives ~ 50-56% overall
    i. Pseudomonas ~ 70%
    ii. Klebsiella
     Serratia ~ 40%
     Enterobacter
    iii. E. coli ~ 30%
  b. gram positives ~ 5-25%
  c. viruses ~ 7%
**Risk Factors**

<table>
<thead>
<tr>
<th>Host Factors</th>
<th>Therapeutic Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>age newborn</td>
<td>ICU or SCN</td>
</tr>
<tr>
<td>elderly &gt; 60</td>
<td>systemic antibiotics</td>
</tr>
<tr>
<td>multiple trauma</td>
<td>invasive catheters</td>
</tr>
<tr>
<td>severe 1° disease</td>
<td>large transfusion</td>
</tr>
<tr>
<td>neutropaenia</td>
<td>need for haemodialysis</td>
</tr>
<tr>
<td>immunosuppression</td>
<td>corticosteroids</td>
</tr>
</tbody>
</table>

**Meduri Chest 1990**

- diagnosis of *nosocomial pneumonia* in an intubated patient is difficult
- *tracheal aspirate* in ventilated patients is often inaccurate & misleading
- *colonisation* rate > 60%
- risk factors for colonisation and infection are similar
- other conditions can simulate pneumonia and may go untreated
- recognition of a specific pathogen is important for effective treatment
- a large number of patients *do not* have pneumonia
- inappropriate antibiotics
  - ↑ colonisation risk → superinfection
  - ↑ resistant bacterial strains
  - potential side effects
  - cost
- many diagnostic techniques - histology = "gold standard"

<table>
<thead>
<tr>
<th>Technique</th>
<th>Sensitivity</th>
<th>Specificity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical</td>
<td>64%</td>
<td>80%</td>
</tr>
<tr>
<td>Tracheal Aspirate</td>
<td>80-95%</td>
<td>40-60%</td>
</tr>
<tr>
<td>LRS</td>
<td>95+%</td>
<td>40%</td>
</tr>
<tr>
<td>Bronchio-Alveolar Lavage</td>
<td>75-100%</td>
<td>30-75%</td>
</tr>
<tr>
<td>Protected Sputum Brushings</td>
<td>40-100%</td>
<td>40-100%</td>
</tr>
</tbody>
</table>

* these figures are from different studies, animal and patient, with different diagnostic criteria for pneumonia
■ **Andrews**  *Chest 1981*

- histology at PM versus *clinical findings* → sensitivity ~ **64%**
  specificity ~ **80%**
  1. fever
  2. leukocytosis
  3. purulent tracheal aspirate
  4. new pulmonary infiltrate on CXR

*NB:* ARDS patients with a new infiltrate frequently *do* have pneumonia, non-ARDS patients with a new infiltrate frequently *do not* have pneumonia

■ **Fagon & Chastre**  *ARRD 1989*

- looking for rate of development of nosocomial pneumonia in intubated ICU patients
- diagnosed with PSB with semiquantitative culture → *sequential incidence*,
  a. day 10 ~ 6.5%
  b. day 20 ~ 19%
  c. day 30 ~ 28% → overall incidence ~ **9%**

- 40% of these were *polymicrobial*
- for the NCP group mortality was 71% cf. 29% in the non-pneumonia group
- the use of antibiotics selects out resistant *Pseudomonas* and MRSA

■ **Salata**  *ARRD 1987*

- 51 intubated ICU patients
- effectiveness of *tracheal aspirate* to distinguish colonisation from infective pneumonia

<table>
<thead>
<tr>
<th></th>
<th>Nosocomial pneumonia</th>
<th>Colonisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>PMN's</td>
<td>&gt; 1+</td>
<td>&lt; 2+</td>
</tr>
<tr>
<td></td>
<td>&gt; 10/hpf</td>
<td></td>
</tr>
<tr>
<td></td>
<td>&gt; 30,000/µl</td>
<td></td>
</tr>
<tr>
<td>Bacteria</td>
<td>&gt; 1+</td>
<td>&lt; 2+</td>
</tr>
<tr>
<td></td>
<td>&gt; 1-10/oil field</td>
<td></td>
</tr>
<tr>
<td>CFU</td>
<td>&gt; 100,000</td>
<td>&lt; 100,000</td>
</tr>
<tr>
<td>ICF organisms</td>
<td>&gt; 1-5% of PMNs</td>
<td>&lt; 1%</td>
</tr>
<tr>
<td>Elastin Fibres</td>
<td>+ve 52% gram(-)</td>
<td>+ve 9%</td>
</tr>
<tr>
<td>Squamous cells</td>
<td>&lt; 10/hpf</td>
<td>&gt; 10/hpf</td>
</tr>
</tbody>
</table>
Johanson, ARRD 1982

- ventilated animal study of diagnostic tools

<table>
<thead>
<tr>
<th>Investigation</th>
<th>Sensitivity</th>
<th>Specificity</th>
</tr>
</thead>
<tbody>
<tr>
<td>TA</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>BAL</td>
<td>74%</td>
<td>?30%</td>
</tr>
<tr>
<td>PSB</td>
<td>40%</td>
<td>?60%</td>
</tr>
<tr>
<td>needle Bx</td>
<td>50%</td>
<td>?50%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Investigation</th>
<th>Sensitivity</th>
<th>Specificity</th>
</tr>
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<tbody>
<tr>
<td>LRS&lt;sup&gt;1&lt;/sup&gt;</td>
<td>100%</td>
<td>40%</td>
</tr>
<tr>
<td>PSB&lt;sup&gt;1&lt;/sup&gt;</td>
<td>80%</td>
<td>100%</td>
</tr>
<tr>
<td>PSB&lt;sup&gt;2&lt;/sup&gt;</td>
<td>70%</td>
<td>100%</td>
</tr>
<tr>
<td>PSB&lt;sup&gt;3&lt;/sup&gt;</td>
<td>100%</td>
<td>60%</td>
</tr>
</tbody>
</table>

1. Richard, ICM 1988, suction samples (LRS) versus PSB (< 10<sup>3</sup> CFU)
2. Higuchi, ARRD 1982, primate model of acute lung injury ± pneumonia
3. Chastre, ARRD 1984, PSB versus immediate post-mortem histology

- Kirkpatrick, ARRD 1988, 8 “normal” subjects studied with BAL & PSB looking at the sterility of the samples, ie. contamination of the specimen
  1. PSB = 7/8 but < 10<sup>4</sup> CFU
  2. BAL = 1/8

- Gassorgues, ICM 1989, BAL vs PM in 13 intubated patients
  → BAL 100% sensitive but 75% specific
• **Chastre & Fagon** *AJM* 1988

  - BAL vs. PSB in 21 intubated ICU patients,
    a. "both useful and complimentary" in diagnosis
    b. BAL → +ve gram stain with **intracellular bacteria** > 25% PMN’s rapid and useful
    - WCC and semi-quantitative cultures (> 10⁴ CFU) less useful
    c. PSB → > 10³ CFU useful in diagnosis but results delayed 48 hrs
    d. PSB gives higher false negatives - ie. **lower sensitivity**
    - supported by below

• **Papazian** *AJRCCM* 1995

  - prospective post-mortem study of diagnostic tool efficacy in diagnosis of VAP
  - histology & culture performed within 30 min of death in 38 patients ventilated > 72 hrs
  a. histology (+) - 18/38 patients ~ 47%
  b. culture (+) - 12/18 patients ~ 32% **definite VAP**

<table>
<thead>
<tr>
<th></th>
<th>Threshold¹</th>
<th>Sensitivity %</th>
<th>Specificity %</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPIS</td>
<td>&gt; 6</td>
<td>72</td>
<td>85</td>
</tr>
<tr>
<td>mini-BAL</td>
<td>&gt; 10³ cfu/ml</td>
<td>67</td>
<td>80</td>
</tr>
<tr>
<td>BAL</td>
<td>&gt; 10⁴ cfu/ml</td>
<td>58</td>
<td>95</td>
</tr>
<tr>
<td>PSB</td>
<td>&gt; 10³ cfu/ml</td>
<td>42</td>
<td>95</td>
</tr>
<tr>
<td>BBS</td>
<td>&gt; 10⁴ cfu/ml</td>
<td>83</td>
<td>80</td>
</tr>
</tbody>
</table>

¹ Figures for **definite VAP**, ie histology & culture positive

• conclusions,
  1. as BBS is more sensitive & non-invasive, ∴ preferrable to PSB
  2. due to **low sensitivity**, results of a negative PSB should be viewed with caution
  3. overall diagnostic **accuracy** was greatest for BBS/BAL at 81%

• CPIS, Pugin *et al.*, ARRD 1991 (Clinical Pulmonary Infection Score)
  1. clinical - temp., quantity & character of tracheal asp.
  2. biological - WCC, PaO₂/FiO₂ ratio
  3. radiographic - CXR
  4. microbiological
Bonten et al. AJRCCM 1995

- evidence for a causal relationship between gastric colonization and VAP based on studies relating colonisation to species causing pneumonia
  Torres et al., ARRD 1993

1. VAP diagnosed by clinical criteria *poor sensitivity/specificity
2. no chronological relationship established
3. gastric pH values determined only once daily by indicator slide test
4. no studies used double-blind PRCT study

- PRCT of 141 patients, of whom 112 had continuous gastric pH monitoring
  a. group 1 58 - antacids, (Al/Mg-OH), 30 ml q4h
  b. group 2 54 - sucralfate 1g q4h

NB: no significant differences in median pH values

- stratifying patients by colonization,
  a. median pH values were higher in patients with gastric bacterial colonization
  b. no difference seen for oropharyngeal or tracheal colonization

ventilator associated pneumonia,
  a. diagnosed by BAL (> 10⁴ CFU) / PSB (> 10³ CFU)
  b. occurred in ~ 22% → same in both groups
  c. polymicrobial in 19/31 episodes → 51 isolates
     i. prior tracheal isolation ~ 96%
     ii. prior oropharyngeal isolation ~ 75%
     iii. prior gastric isolation ~ 31%

NB: in one case the organism resulting in VAP initially colonized the stomach, in five cases, colonization occurred simultaneously

- this is supported by Inglis et al., Lancet 1993, who showed chronological colonization from stomach to trachea in only 6/100 ventilated patients

- enteral feeding,
  a. did not alter gastric acidity
  b. increased gastric colonization with Enterobacteriaceae
  c. no change in oropharyngeal or tracheal colonization
  d. confounding factor of ↑gastric volume controlled

NB: gastric acidity influenced gastric colonization, but not colonization of the upper respiratory tract or the incidence of VAP
ICU Pneumonias

1. early onset $\leq 4$ days
2. nosocomial, or late onset

- the *incidence* of ICU acquired pneumonia $\sim 21\%$
- and $\sim 54\%$ of these occur within the first 4 days
- risk factors include,
  a. impaired airway reflexes
  b. severity of underlying pathology
  c. duration in ICU

### Early Onset Pneumonia

- a. occurs within 4 days
- b. is very common
- c. is unrelated to - age
  - type of illness
  - immune suppression
- d. frequently oropharyngeal pathogens
- e. mainly in intubated patients
- f. little affected by antibiotic prophylaxis

### Late Onset Pneumonia

- a. usually gram (-)ve pathogen
- b. frequently impaired airway reflexes
- c. should (?) be influenced by antibiotic prophylaxis
Haemoptysis

a. **airways**
   - trauma
   - tumour
   - infection
   - FB

b. **lung**
   - trauma
   - tumour, 1° or 2°
   - infection, inflammation/vasculitis, infarction

c. **CVS**
   - LVF, MS
   - pulmonary emboli, infarction
   - pulmonary AVM

d. **coagulopathy**

**Def'n:** massive haemoptysis, defined arbitrarily as blood loss,

1. between 200-600 ml expectorated per 24 hours, or
2. resulting in acute airway obstruction, or
3. resulting in acute hypotension

- more than 90% of cases are due to chronic infection, as inflammation leads to profuse vascularisation of the high pressure bronchial circulation
- the most common causes are,
  1. TB
  2. bronchiectasis / pulmonary abscess
  3. bronchial neoplasms

- resections for haemoptysis > 600 ml/24 hrs carry a high mortality rate ~ 15-20%
- this is better than conservative management, which averages up to 75%
- surgery is probably indicated in those patients who,
  a. require multiple transfusion
  b. show progressive deterioration of pulmonary function
  c. continue to bleed despite adequate medical management

- surgery is probably contra-indicated in those patients who,
  a. have inoperable bronchial carcinoma
  b. fail to have their bleeding site localised
  c. have severe bilateral pulmonary disease
  d. have severe debilitating systemic disease
most patients should have a **rigid bronchoscopy**, due to the greater ease of ventilation and suctioning

- upper lobe bleeding may require the use of a flexible scope
- moderate bleeding may be controlled through the bronchoscope
- prevention of soiling of the innocent lung may be achieved by the use of a bronchial blocker, such as a balloon-tipped Fogarty catheter, or DLT intubation
- if the patient is deemed inoperable, then bronchial **embolisation** may be attempted

**Anaesthetic Principals**

1. preoxygenation and ventilation with 100% O₂
2. several large bore IV canulae should be inserted
3. the patient should be cross-matched + baseline FBE
4. the patients coagulation profile should be checked
5. antibiotics should be commenced preoperatively
6. adequate suctioning should be available
7. **on induction** the bleeding lung should be **dependent**, and anti-aspiration measures should be employed
8. alternatively, in the patient with massive haemoptysis, an awake, semi-upright intubation may be required
9. separation of the two lungs, - DLT
    - SLT + bronchial blocker
10. IPPV + PEEP - with regular intermittent suctioning

**NB:** after the airway is secured and the lungs **separated**, the bleeding lung should be in the **non-dependent** position

- patients are frequently **hypovolaemic**, therefore induction should follow adequate volume replacement and should be achieved with either a small dose of STP or ketamine, or alternatively use narcotics
- if a SLT is already in place, consideration should be given to,
  a. replacing it with a DLT
  b. the addition of a bronchial blocker
  c. endobronchial intubation
DIFFUSE INFILTRATIVE LUNG DISEASE

- **Aetiology**
  a. idiopathic
  b. infective
  c. circulatory
  d. inflammatory / autoimmune
  e. neoplastic
  f. industrial / occupational diseases
  g. iatrogenic - drug induced, radiation, O₂ toxicity
  h. metabolic
  i. congenital
  j. physical

- **Differential Diagnosis**
  a. **infective pneumonias**
    i. community acquired
      • typical - Streptococcal
        - Haemophilus
      • atypical - influenza, parainfluenza
        - mycoplasma, Legionella, Chlamydia
      • uncommon - other viruses
        - Coxiella
        - TB
        - fungi
        - Pneumocystis
        - Brucella
        - Leptospirosis
        - Syphilis
        - MRSA
    ii. hospital acquired - gram (-)ves
      - staphylococcal, MRSA
      - anaerobes
      - fungi
  b. **septicaemia** ± DIC
c. **occupational diseases**
   i. pneumoconioses - asbestosis, silicosis, berylosis, coal workers disease
   ii. zoonoses
   iii. chemical pneumonitis

d. **neoplasms**
   - bronchogenic carcinoma
   - alveolar cell carcinoma
   - lymphomas, leukaemias
   - metastatic carcinomas, lymphangitic carcinomatosis

e. **congenital**
   - cystic fibrosis
   - \( \alpha \)-antitrypsin deficiency

f. **metabolic**
   - uraemia
   - hypercalcaemia
   - haemosiderosis

g. **physical**
   - irradiation
   - heat, thermal
   - oxygen toxicity
   - blast injury

h. **circulatory**
   - LVF
   - mitral stenosis
   - thromboembolic disease
   - bacterial endocarditis

i. **immunological**
   i. hypersensitivity
      - allergic alveolitis - farmer's lung, bird fancier's lung
      **drugs**
   ii. autoimmune - SLE, RA, scleroderma, polyarteritis nodosa
       - Wegener's granulomatosis
       - dermatomyositis/polymyositis
       - Goodpasture's synd.

j. **drugs**
   i. cytotoxic agents - adriamycin, bleomycin, busulphan, cyclophosphamide
      - hydroxyurea, methotrexate, mitomycin
   ii. non-cytotoxics - amiodarone, acetylsalicylic acid, chlorpropamide
      - carbamazepine, hydralazine, penicillamine
      - phenytoin, lignocaine, methadone, heroine
   iii. toxins - paraquat

k. **idiopathic**
   - idiopathic pulmonary fibrosis
   - familial pulmonary fibrosis
   - sarcoidosis
   - alveolar proteinosis
   - amyloid
Causes of Infective Pneumonias

a. **viruses**
   - influenza A & B, parainfluenza
   - CMV, RSV, varicella
   - rhinoviruses, adenoviruses, enteroviruses

b. **bacteria**
   i. gram (+)'ve cocci
      - Staphlococci* *aerobic
      - Streptococci*
      - Micrococi - anaerobic
   ii. gram (-)'ve cocci
      - Branhamella, Acinetobacter
   iii. gram (+)'ve rods
      - Bacillus, Lactobacillus
      - Clostridia
      - Nocardia
   iv. gram (-)'ve rods
      - Haemophilus
      - Klebsiella
      - Legionella
      - E. coli
      - Enterobacter, Proteus, Serratia
      - Pasteurella, Yersinia, Citrobacter
      - Salmonella, Shigella
      • anaerobes
         - Bacteroides
      • obligate anaerobes
         - Bordetella
         - Brucella
   v. acid fast bacilli
      - Mycobacterium tuberculosis, M. kansii

c. **cell wall deficient bacteria**
   * obligate intracellular parasites
      - Coxiella burnetti
      - Mycoplasma pneumoniae
      - Chlamydia psittaci

d. **fungi**
   - Aspergillus niger, Aspergillus fumigatus
   - Candida albicans, Cryptococcus
   - Histoplasma
   - Coccidioides
   - Sporotrichum
   - Blastomyces

e. **protozoa**
   - Pneumocystis (rRNA ? fungal phylogeny)
   - Toxoplasma
   - Entamoeba
   - Strongyloides, Ascaris lumbricoides
   - Toxocara carnis (visceral larva migrans)
   - Echinococcus (hydatid disease)
   - Schistosomiasis (blood fluke)
   - Paragonomiasis (lung fluke)
Environmental Factors

a. **minerals**
   - silicon, asbestos
   - beryllium
   - coal, bauxite
   - diatomaceous earth, talc
   - iron, barium, silver, tin
   - manganese, vanadium

b. **fumes**
   - nitrogen dioxide
   - chlorine, bromine
   - ammonia
   - phosgene, sulphur dioxide
   - acetylene, kerosene, carbon tetrachloride, hydrogen fluoride
   - hydrochloric, nitric, picric acids

c. **antigens**
   - Farmer's lung
   - pigeon fanciers lung
   - humidifiers, air-conditioners
   - maple bark, wood pulp, oak
   - mushroom, malt, sugar cane
   - furrier's
   - detergents, vineyard sprayers
   - fish, cheese, wheat weevil

d. **drugs**
   - hydrallazine
   - busulphan, bleomycin, methotrexate
   - nitrofurantoin, sulphas
   - methysergide
   - *amiodarone*

e. **poisons**
   - paraquat
   - petroleum derivatives
Investigation Stage 1

a. **History**
   i. age, family history
   ii. drugs, smoking, allergies
   iii. occupation, pets / animals, hobbies, environment
   iv. personal contacts, friends / relatives
   v. overseas travel
   vi. nature, severity and time course of symptoms
   vii. past medical history - esp. CVS / RS

b. **Examination**
   i. upper & lower respiratory tracts
      * amount & type of sputum
      * presence/severity of respiratory failure
   ii. cardiac bruits/failure
   iii. vital signs
   iv. liver/spleen size, lymph nodes
   v. fundi
   vi. skin manifestations - purpura, erythema

Investigation Stage 2

a. FBE, ESR
b. blood film
   i. RBC's: anaemia, haemolysis, agglutination
   ii. WBC's: left shift, eosinophilia, blasts
c. U,C&E's, LFTs
d. blood cultures
e. sputum - M, C & S
   - cytology
   - AFB micro and culture
f. urine - M, C & S
   - sediment examination for active changes
   - haematuria
g. CXR
h. ECG
i. Echo
**Investigation Specialized**

1. **blood**
   i. paired serology
      - viruses, Legionella, Q fever, Chlamydia, Mycoplasma and fungi/parasites
   ii. cold agglutinins
   iii. HTLVIII / HIV Ab titre
   iv. autoantibodies - RF, SLE, cANCA, Goodpastures, ENA
   v. coagulation profile - INR, APTT, FDP’s, fibrinogen
   vi. protein electrophoresis - immune complexes, myeloma
      - $\alpha_1$-antitrypsin deficiency

2. **sputum**
   i. Ziehl-Neilson stain & culture for AFB’s
   ii. immunofluorescence microscopy - Legionella
      - Influenza
   iii. silver stain - Pneumocystis
      - *3% saline induced sputum
   iv. wet preparation - parasites $\rightarrow$ ova, cysts, larvae
      - yeasts $\rightarrow$ hyphae

3. **nasopharyngeal washings** - viruses

4. **mantoux skin test**

5. **viral cultures** - throat swabs
   - faecal and sputum samples

6. **faecal specimens (x3-6)** - micro $\rightarrow$ protozoan cysts, ova
   - culture $\rightarrow$ bacterial, viral

7. **PA catheter** - exclude / confirm LVF

8. **echocardiogram** - SBE $\rightarrow$ low sensitivity, $\therefore$ use TOE
   - atrial myxoma
   - LV function, valvular competence

9. **ultrasound** - liver / spleen / kidneys
   - fluid collections, abscesses
   - tumours

10. **CT chest & abdomen** - abscess, tumour
    - lymphadenopathy, mediastinal masses
    - CT directed biopsy
    - fine-cut CT chest - moderate ability to differentiate pathology
11. **bronchoscopy**
   i. brushings - MC&S
      - cytology
      - differential WCC
   ii. washings - as above
   iii. bronchiolar lavage - MC&S
      - effector cell type & count
   iv. biopsy - tumours
      - asthma
      - transbronchial lung biopsy

12. **open lung biopsy**, if
   i. diagnosis remains unclear after the above
   ii. the condition deteriorates despite empirical treatment
   iii. prior to a trial of immunosuppressives or steroids
   iv. no other (more accessible) organ is involved in the disease
      →
      - MC&S
      - M&C for AFB's
      - histopathology & frozen section
      - silver stain for Pneumocystis
      - immunoflorescence for Legionella

13. **pleural fluid** - MC&S
    - cytology
    - biochemistry, pH, LDH, protein

14. **renal biopsy** - autoimmune diseases
    - Goodpasture's

15. **bone marrow biopsy** - metastatic carcinoma
    - myeloma leukaemia, lymphoma
    - TB culture
Interstitial Pneumonitis

a. idiopathic interstitial pneumonitis
b. familial pulmonary fibrosis
c. autoimmune diseases - rheumatoid arthritis, SLE
   - Wegener's granulomatosis, Goodpastures syndrome
   - scleroderma, polyarteritis nodosa, dermatomyositis
d. sarcoidosis
e. alveolar proteinosis
f. congenital - cystic fibrosis
   - $\alpha_1$-antitrypsin deficiency
g. pneumoconioses - silicon, asbestos
   - beryllium, coal, bauxite
   - diatomaceous earth, talc
   - iron, tin, barium, silver, manganese, vanadium
h. chemical pneumonitis - nitrogen dioxide, chlorine, bromine
   - phosgene, ammonia, sulphur dioxide
   - acetylene, kerosene, carbon tetrachloride, hydrogen fluoride
   - hydrochloric acid, nitric, picric acids
i. extrinsic allergic alveolitis - farmer's lung, bird fanciers lung
   - maple bark, wood pulp, oak
   - mushroom, malt, sugar-cane
   - furrier's, detergents, vineyard sprayers
   - humidifiers, airconditioners, etc.
j. drug-induced
   intrinsic allergic alveolitis - hydrallazine, methotrexate
   - busulphan, bleomycin, nitrofurantoin
   - methysergide, amiodarone
   - sulphur derivatives
k. amyloidosis

- Interstitial Pneumonitis *Common Causes

1. infective pneumonia
2. atypical pneumonia
3. malignancy
4. lymphangitis carcinomatosis
5. chronic LVF
**Upper Lobe → SCHART**

1. **S** - silicosis (progressive massive fibrosis)  
   - sarcoidosis
2. **C** - coal workers pneumoconiosis
3. **H** - histiocytosis X
4. **A** - ankylosing spondylitis, aspergillosis
5. **R** - radiation
6. **T** - TB

**Lower Lobe → RASIO**

1. **R** - rheumatoid arthritis
2. **A** - asbestosis
3. **S** - scleroderma
4. **I** - idiopathic
5. **O** - other  
   - busulphan, bleomycin, amiodarone, methotrexate
FAT EMBOLISM SYNDROME

Def'n:  clinical syndrome of pulmonary & systemic embolic features, associated with a predisposing cause for bone marrow/fat emboli

- **Aetiology**
  
  a. pelvic, or long bone fractures  
     ~ 100% have emboli  
     ~ 5% develop FES  
     (LIGW ~ 1-2%)
  
  b. orthopaedic surgical procedures  
     ~ 60% have emboli  
     - FES rare
  
  c. hyperlipidaemic states  
     - pancreatitis  
     - diabetes mellitus  
     - lipid infusions  
     - hepatic failure or trauma  
     - SLE  
     - nephrotic syndrome
  
  d. adipose trauma  
     - crush injury  
     - bends  
     - liposuction  
     - lymphography
  
  e. others  
     - external cardiac massage  
     - poisoning  
     - sickle cell crisis  
     - extracorporeal circulation

NB:  for (c-e) the majority of these, the finding is usually a post-mortem one, they rarely result in clinically significant FES

- **Massive Fat Embolism**
  
  - distinct from FES, with the clinical picture being that for any massive embolic syndrome  
  - this may be exaggerated by platelet aggregation and granule release  
  - lethal dose of fat for an average adult estimated at ~ 50-70 ml  
  - cf. the volume of fat contained in the femur ~ 70-100 ml
Clinical Features

**NB:** 1 major and 3 minor criteria are as sensitive & specific as any laboratory test

a. **major features**
   i. petechial rash - chest, neck, palate, retina
      ~ 25-50%
      • this is the only feature **pathognomic** of FES
      • usually appears on 2nd-3rd days and lasts 2-3 days
   ii. respiratory dysfunction
      • arterial hypoxaemia & bilateral CXR infiltrates
   iii. CNS dysfunction
      • drowsiness, confusion, convulsions, coma
      • * unrelated to head injury or other cause

b. **minor features**
   i. tachycardia
   ii. pyrexia - 38°-39°C
      ~ 60%
   iii. FBE - sudden fall in [Hb]
      - sudden thrombocytopaenia
      - high ESR
   iv. fundi - fat emboli, petechial haemorrhages
   v. urine - anuria, oliguria
      - fat globules
   vi. sputum - fat globules

Laboratory Investigations

1. arterial hypoxaemia
2. fat globules - blood, urine or sputum
   * nonspecific and may occur in other conditions
3. haemolytic anaemia
4. thrombocytopaenia
5. hypocalcaemia
6. elevated serum lipase

Management

• heparin, aspirin, glucose, steroids & aprotinin **do not** alter incidence or mortality
• therapy is largely supportive once established
• **all** long bone fractures should be immobilized early
CHRONIC AIRFLOW LIMITATION

**Def’n:** Asthma: $\geq 15\% \Delta \text{FEV}_1$ with - bronchodilators
- methacholine, histamine challenge

**Chronic bronchitis:**
morning cough with sputum production for $> 3$ months of the year for $2$ successive years, in the absence of any underlying disease which may account for these symptoms

**Emphysema:** abnormal, permanent enlargement of the airways distal to the *terminal bronchiole*, with destruction of their walls and without obvious fibrosis (ATS), or diminished gas transfer interface (area), $\downarrow \text{DL}_{\text{CO}}$

- **Smoking**
  1. produces both chronic bronchitis & emphysema, but little reversible airways disease
  2. impaired ciliary function & sputum clearance
  3. immunoparesis
  4. $\uparrow$ frequency of upper & lower respiratory tract infections
  5. $\uparrow$ COHb - chronic tissue hypoxia
- polycythaemia
  6. nicotine - hypertension, $\uparrow$ SAP & DAP, $\uparrow$ PVR
  7. accelerated atherosclerosis
  8. $\uparrow$ platelet adhesiveness
  9. major risk factor for ischaemic heart disease
  10. increased peripheral vascular disease
  11. increased bronchogenic carcinoma $> 10$ pkt/years (1 pkt/yr = 20/d)
### Exacerbation of CAL

- **respiratory**
  - infection - bacterial, viral, fungal
  - aspiration
  - bronchospasm
  - pneumothorax
  - trauma, surgery
  - neoplasm
  - air pollutants

- **cardiac**
  - AMI
  - LVF, pulmonary oedema
  - pulmonary emboli
  - arrhythmia

- **drugs**
  - sedatives, opioids
  - anaesthetics
  - muscle relaxants

- **metabolic**
  - fever
  - sepsis
  - pancreatitis
  - hyperthyroidism

- **electrolytes**
  - low $K^+$, $Mg^{++}$, $PO_4^{2-}$
  - metabolic alkalosis

- **other**
  - malnutrition
  - high CHO intake
  - depression of hypoxic drive
<table>
<thead>
<tr>
<th>Acute Respiratory Failure</th>
<th>Complications</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. hypoxaemia</td>
<td>- organ ischaemia / infarction</td>
</tr>
<tr>
<td></td>
<td>- mental confusion, agitation</td>
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<tr>
<td>b. pulmonary</td>
<td>- infection</td>
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<td></td>
<td>- aspiration</td>
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<td></td>
<td>- barotrauma</td>
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<tr>
<td></td>
<td>- fibrosis</td>
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<tr>
<td></td>
<td>- pulmonary emboli</td>
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<tr>
<td>c. cardiovascular</td>
<td>- hypertension, tachycardia, arrhythmias</td>
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<td></td>
<td>- late hypotension, bradycardia, QRS prolongation, EMD</td>
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<td></td>
<td>- altered organ perfusion</td>
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<td>d. CNS</td>
<td>- anxiety, distress</td>
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<td></td>
<td>- acute psychosis</td>
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<td>- obtundation, coma</td>
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<td>- ↑ ICP</td>
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<tr>
<td>e. renal</td>
<td>- acute renal failure</td>
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<td>- salt &amp; water retention</td>
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<tr>
<td>f. GIT</td>
<td>- pneumoperitoneum</td>
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<tr>
<td></td>
<td>- ileus, gastric dilatation</td>
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<td></td>
<td>- acalculous cholecystitis</td>
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<td></td>
<td>- mucosal atrophy (TPN)</td>
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<tr>
<td>g. nutritional</td>
<td>- malnutrition</td>
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<tr>
<td></td>
<td>- muscle wasting</td>
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<tr>
<td>h. microbiology</td>
<td>- nosocomial pneumonia</td>
</tr>
<tr>
<td></td>
<td>- bacteraemia, septicaemia</td>
</tr>
<tr>
<td>i. technical</td>
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<td>i. IV access</td>
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<td>ii. mask CPAP</td>
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<td>iii. intubation</td>
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<td>iv. mechanical ventilation</td>
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<td>v. PA catheter problems</td>
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<td>j. drug side effects</td>
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<td>i. steroids</td>
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<td></td>
<td>ii. antibiotics</td>
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<td>iii. aminophylline</td>
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<td>iv. β-agonists</td>
</tr>
</tbody>
</table>
BRONCHIAL CARCINOMA

- **Clinical Presentation**

1. **pulmonary**
   - i. bronchial obstruction - collapse
     - pneumonia, abscess, empyema
     - emphysema
   - ii. pleural effusion
   - iii. bleeding / haemoptysis
   - iv. SVC obstruction
   - v. Horner's syndrome
   - vi. brachial plexus or T1 lesion
   - vii. recurrent laryngeal nerve or phrenic nerve palsy
   - viii. incidental lesion on CXR

2. **metastatic disease**
   - i. bone pain, pathological fracture, hypercalcaemia
   - ii. hilar and cervical lymphadenopathy
   - iii. cerebral
   - iv. adrenal

3. **paraneoplastic**
   - i. cachexia
   - ii. anaemia of chronic disease
   - iii. hypertrophic osteoarthropathy - finger clubbing
     - arthritis, periosteal new bone
   - iv. neuropathy
   - v. myopathy - carcinomatous myopathies
     - Eaton-Lambert syndrome
   - vi. skin lesions - pigmentation, erythema
     - scleroderma, acanthosis nigra
     - herpes zoster, herpes simplex
   - vii. endocrine
     - ectopic ADH → SIADH
     - ectopic PTH → hypercalcaemia
     - ectopic TSH → thyrotoxicosis
     - ectopic ACTH → Cushing's syndrome
     - carcinoid syndrome
     - gynaecomastia
   - viii. haematological - aplastic anaemia
     - thrombophlebitis
     - DVT's
**CXR**

a. changes usually antedate symptoms by ~ 7 months  
b. symptoms → abnormal CXR ~ 98%  
c. further, the changes are suggestive of tumor in ~ 80%  
d. ~ 70% are centrally located  
e. at presentation, average size is ~ 3-4 cm  
f. other important diagnostic features include,  
   i. tracheal deviation/obstruction  
   ii. mediastinal mass - SCV, PA, main bronchi  
   iii. pleural effusions  
   iv. cardiac enlargement  
   v. bullous cyst - rupture, compression  
   vi. air-fluid levels ? abscess, soiling  
   vii. parenchymal changes - V/Q inequality

**Inoperability of Bronchial Carcinoma**

1. distant metastases - brain, liver, adrenals & bone  
2. malignant pleural effusion  
3. recurrent laryngeal nerve involvement  
4. phrenic nerve involvement  
5. regional lymph nodes within 2 cm of the hilum  
6. high paratracheal, or contralateral hilar spread  
7. SVC syndrome  
8. PA involvement  
9. cardiac tamponade  
10. bilateral disease

**NB:** operability also depends upon *cell type*. 
unilateral or pleural spread may be operable with less invasive cell types
# Pneumonectomy Assessment

<table>
<thead>
<tr>
<th>Test Type</th>
<th>PFT</th>
<th>Risk Limits for <em>Pneumonectomy</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Whole-Lung Tests</td>
<td>AGB's</td>
<td>• <em>hypercapnia</em> on room air</td>
</tr>
<tr>
<td></td>
<td>Spirometry</td>
<td>• FEV₁/FVC ≤ 50%</td>
</tr>
<tr>
<td></td>
<td>Lung volumes</td>
<td>• FVC ≤ 2.0 l</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• MBC ≤ 50%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• RV/TLC ≥ 50%</td>
</tr>
<tr>
<td>Single Lung Tests</td>
<td>Split function tests (R&amp;L)</td>
<td>• predicted FEV₁ ≤ 0.85 l</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• PBF &gt; 70% diseased lung</td>
</tr>
<tr>
<td>Simulated Pneumonectomy</td>
<td>Balloon occlusion</td>
<td>• mean PAP ≥ 40 mmHg</td>
</tr>
<tr>
<td></td>
<td>R/L PA</td>
<td>• PaCO₂ ≥ 60 mmHg</td>
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<tr>
<td></td>
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<td>• PaO₂ ≤ 45 mmHg</td>
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</tbody>
</table>
COR PULMONALE

**Def’n:** RV enlargement 2° to thoracic, lung or pulmonary vascular disease, in the absence of congenital, or left sided heart disease; *RV failure is not required for the diagnosis*

*right heart failure* is defined as a chronic increase in the RV end-diastolic transmural pressure gradient, that is not expected from an increase in pulmonary blood flow (HPIM, 12th Ed)

### Aetiology

1. pulmonary *vascular* disease
   - primary pulmonary hypertension
   - chronic multiple emboli
   - pulmonary vasculitis
2. chronic *parenchymal* lung disease
   - CAL
   - diffuse interstitial lung diseases
3. lung *pump* failure
   - kyphoscoliosis
   - neuromuscular diseases
   - morbid obesity
4. *central drive* failure
   - obstructive sleep apnoea syndrome
   - chronic mountain sickness

### Pathogenesis

**NB:** may be either - acute or chronic
- episodic or progressive

a. acute → RV dilatation
b. chronic → RV hypertrophy, later dilatation

- initially PAH occurs only during *exercise* or during stress
- this is accompanied by episodic RV dilatation with normal RVEDP and RV output
- later, persistent PAH leads to RV hypertrophy ± dilatation
- this is associated with sustained high RVEDP's and RVF, initially during exercise but later at rest
Mechanisms

a. loss of vascular bed
b. irreversible pulmonary vasoconstriction
   i. chronic hypoxia
   ii. chronic acidosis  pH < 7.2
   iii. chronic hypercapnia

Exacerbating Factors

1. progression of 1° lung disease
2. intercurrent respiratory infection
3. pulmonary emboli
4. cardiac decompensation  - arrhythmias
   - RV ischaemia
5. sedative & analgesic drugs
6. ↑ work of breathing  - resistance (bronchospasm)
   - compliance
7. hypercatabolic states  - surgery, trauma
   - endocrine
8. surgery  - pulmonary resection
   - upper abdominal/thoracic

Signs

a. stigmata of chronic lung disease
   - nicotine stains
   - dyspnoea, tachypnoea
   - central cyanosis
   - clubbing, skin changes
   - asterixis
b. RV hypertrophy
   - RV thrust ± palpable P₂
   - loud P₂ & wide split S₂
   - RV-S₄
   - TI
   - recurrent SVT, MAT

c. RV failure
   - high JVP
   - peripheral oedema
   - ascites, hepatomegaly
Symptoms

a. those of chronic bronchitis / emphysema
b. dyspnoea
c. tiredness, fatigue, decreased exercise tolerance
d. peripheral oedema
e. palpitations - AF
f. daytime somnolence - OSAS

Investigations

a. FBE, ESR - polycythaemia, anaemia chronic disease
   - ↑ WCC, left shift
b. EC&U, LFT's, AGA
c. ECG - P pulmonale
   - RVH (qv), RAD, RBBB
   - sinus tachycardia, AF, MAT
   • RVH on ECG is rare except in primary pulmonary hypertension
   • 'q'-waves in II, III, aVF may simulate AMI due to vertically placed heart
d. CXR - lung disease with large PA's
   - peripheral field oligaemia
   - usually no LVF or cardiomegaly
e. PFT's - obstructive | restrictive components
   ± reversibility
f. Echo - dilated RV
   ± TI
g. V/Q Scan - to exclude chronic PE

Complications

1. acute respiratory failure
2. recurrent respiratory infections
3. chronic hypoxia
4. polycythaemia
5. right heart failure
6. arrhythmias
7. sudden death (1° PAH)
8. cirrhosis
Treatment

a. treat primary lung disease & cease smoking

b. optimise remaining lung function
   i. lose weight
   ii. bronchodilators
   iii. steroids
   iv. diuretics
   v. antibiotics
   vi. physiotherapy

c. prompt treatment of chest infections

d. prevent pulmonary emboli

e. respiratory stimulants (aminophylline)

f. improve cardiac function
   i. digoxin
   ii. antiarrhythmics
   iii. diuretics

g. pulmonary vasodilators
   i. nitric oxide ~ 10-40 ppm
   ii. PGI₂ ~ 5-35 ng/kg/min
      • expensive pulmonary & systemic vasodilator
      • PA catheter required for monitoring
      • noradrenaline 1 µg/min can be used to overcome the systemic vasodilation
      • side effects include systemic vasodilatation, hypotension and nausea
      • some units are now using this via the inhaled route
   iii. adenosine ~ 50-500 µg/kg/min
   iv. GTN
   v. ACEI
   vi. β₂-agonists - isoprenaline
      • dopexamine
   vii. Ca²⁺ entry blockers

h. heart/lung transplantation
OBESITY HYPOVENTILATION SYNDROME

- **Clinical Features**
  1. marked obesity
  2. hypersomnolecence - especially daytime
  3. periodic breathing
  4. central *and* obstructive apnoea
  5. pulmonary hypertension
  6. cor pulmonale ± RF failure

- **Diagnostic Investigations**
  1. hypercapnoea
  2. hypoxia - especially night-time / sleep studies
  3. polycythaemia
  4. depressed ventilatory response to CO\(_2\) & O\(_2\)

- **Rochester 1974**
  - common mechanical and circulatory factors in *morbid obesity*.
    a. lung volumes  ↓ FRC
      ↓ VC
    b. lung function  ↓ MBC (MVV)
      ↓ lung and chest wall compliance
      ↓ respiratory muscle efficiency  ~ 30%
    c. ↑ V/Q mismatch - V to apices
      - Q to bases
    d. ↑ cardiac output  ~ 100-400%
    e. ↑ pulmonary and systemic blood volume
    f. pulmonary hypertension

*NB:* these changes are *proportional* to the degree of *obesity*
Leech 1987

- multiple regression analysis of factors associated with hypercarbia and sleep apnoea, (p < 0.05)
  a. obesity - height/weight ratio
  b. ↓ FVC & FEV₁ - absolute volume changes, cf. predicted
  c. daytime hypoxia  \( P_{aO_2} < 70 \text{ mmHg} \)
  d. severity of desaturation during sleep apnoeic periods

- factors with poor, or no association,
  a. age
  b. FEV₁/FVC ratio - ie. airflow obstruction
  c. the number of sleep induced respiratory events
  d. the \( P_{A-aO_2} \) gradient

- the syndrome is multifactorial,
  1. chronic hypoxia
  2. ↑ work of breathing
  3. altered \( O_2/CO_2 \) drives

Aetiology

- suggested factors include,
  a. ↑ weight → ↑ mechanical load
  b. obstructive airways disease *not supported by Leech above
  c. impaired respiratory mechanics & muscle function
  d. central sleep-apnoea
  e. ↑ V/Q mismatch, shunt and dead space
  f. impaired respiratory control mechanisms, ie. \( O_2/CO_2 \) drive
<table>
<thead>
<tr>
<th>Parameter</th>
<th>Simple Obesity</th>
<th>OHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total compliance</td>
<td>slight fall</td>
<td>30% fall</td>
</tr>
<tr>
<td>Lung compliance</td>
<td>25% fall</td>
<td>40% fall</td>
</tr>
<tr>
<td>V/Q, Shunt</td>
<td>increased mismatch</td>
<td>large mismatch</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&lt; 40% shunt</td>
</tr>
<tr>
<td>Work of breathing</td>
<td>30% increase</td>
<td>300% increase</td>
</tr>
<tr>
<td>VO₂ cost of breathing</td>
<td>↑ VO₂ ~ ↑ work</td>
<td>↑↑ VO₂ &gt;&gt; ↑ work</td>
</tr>
<tr>
<td>Diaphragm response to ↑ PₐCO₂</td>
<td>increases</td>
<td>300-400% decrease</td>
</tr>
</tbody>
</table>

**Effects of weight-loss on the following variables**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Simple Obesity</th>
<th>OHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>PₐCO₂</td>
<td>no change</td>
<td>decreases</td>
</tr>
<tr>
<td>VC</td>
<td>increase</td>
<td>marked increase</td>
</tr>
<tr>
<td>MBC</td>
<td>increase</td>
<td>increase</td>
</tr>
<tr>
<td>Apnoeic periods</td>
<td>decrease</td>
<td>marked decrease</td>
</tr>
<tr>
<td>Level of desaturation</td>
<td>improved</td>
<td>markedly improved</td>
</tr>
</tbody>
</table>
**Sampson, Grassimo 1983**

- during quiet breathing there is little difference in the following parameters,
  a.  $V_T$, VC, TLC, FRC, RV, ERV, FEV$_1$/FVC, and RR
  b.  ABG's
  c.  mouth occlusion pressure
  d.  age, sex, weight

  however, during *hypercapnoeic rebreathing*,

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Normal</th>
<th>Obese</th>
<th>OHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rebreathing (l/min/mmHg-CO$_2$)</td>
<td>3.5</td>
<td>1.83</td>
<td>1.06</td>
</tr>
<tr>
<td>Mouth occlusion pressure (cmH$_2$O/mmHg-CO$_2$)</td>
<td>0.5-0.6</td>
<td>0.91</td>
<td>0.29</td>
</tr>
<tr>
<td>Diaphragmatic EMG ($\delta$/mmHg-CO$_2$)</td>
<td>25%</td>
<td>23.8%</td>
<td>13.9%</td>
</tr>
<tr>
<td>CO$_2$-Response</td>
<td>normal or increased</td>
<td>blunted</td>
<td></td>
</tr>
</tbody>
</table>

**Obesity Hypoventilation Syndrome**

- lung volumes are similar in OHS/SO, ∴ it is unlikely that OHS relates solely to *muscle weakness*
- the slope of the CO$_2$-ventilation curve is altered, not shifted in a parallel fashion
- muscle diseases show a different pattern, with the diaphragmatic EMG showing the same pressure gradient
- the disease therefore, in summary, is
  a.  multifactorial
  b.  related to
    i.  mechanical load
    ii. sleep apnoea
    iii. chronic hypoxia
    iv.  altered central respiratory drive
    v.  ? enhanced buffering of metabolic alkalosis

**NB:** represent a sub-group of obese patients, with probable pre-existing impaired central response to CO$_2$ and O$_2$, in whom the added load of obesity results in chronic respiratory failure, ie.

"*non-fighters, unable to prevent CO$_2$ retention*"
PNEUMOTHORAX

NB: tension pneumothorax, from any cause but especially.

1. chest trauma
2. barotrauma during mechanical ventilation
3. obstructed pleural drains

- **Aetiology**
  
a. trauma
b. surgery
c. lung diseases  
  - asthma
  - infections
  - emphysema
  - pulmonary infarction
  - bullous disease
d. iatrogenic  
  - CVC cannulation
  - tracheostomy
  - U-S/CT guided drainage/biopsy
  - bronchoscopy
  - thoracentesis
e. barotrauma  
  - artificial ventilation
  - diving
  - aviation, training
f. idiopathic
PLEURAL EFFUSION

**Def'n:** an *exudate* is pleural fluid having *one or more* of the following

1. fluid:serum protein ratio *> 0.5* * protein * > 30 g/l
2. fluid:serum LDH ratio *> 0.6*
3. absolute fluid LDH *> 2/3 normal serum upper limit* * > 200 U/l

<table>
<thead>
<tr>
<th>Transudative</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CCF</td>
</tr>
<tr>
<td>2. cirrhosis, ascites</td>
</tr>
<tr>
<td>3. renal failure, nephrotic syndrome</td>
</tr>
<tr>
<td>4. hypoproteinaemia</td>
</tr>
<tr>
<td>5. peritoneal dialysis</td>
</tr>
<tr>
<td>6. myxoedema</td>
</tr>
<tr>
<td>7. Meig’s syndrome + ascites &amp; ovarian fibroma</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exudative</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. infectious</td>
</tr>
<tr>
<td>2. inflammatory - collagen vascular disorders</td>
</tr>
<tr>
<td>3. neoplastic</td>
</tr>
<tr>
<td>4. pulmonary infarction</td>
</tr>
<tr>
<td>5. traumatic - haemo/chylo-thorax</td>
</tr>
<tr>
<td>6. drugs - nitrofurantoin, methysergide</td>
</tr>
<tr>
<td>7. GIT - subphrenic abscess</td>
</tr>
<tr>
<td>8. uraemia</td>
</tr>
<tr>
<td>9. post-AMI</td>
</tr>
<tr>
<td>10. other - asbestosis, DXRT</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. full history and examination</td>
</tr>
<tr>
<td>2. treat obvious cause</td>
</tr>
<tr>
<td>3. thoracentesis ± pleural biopsy if suspected exudate</td>
</tr>
</tbody>
</table>
**ICU - Respiratory**

<table>
<thead>
<tr>
<th></th>
<th>Transudate</th>
<th>Exudate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Appearance</strong></td>
<td>clear</td>
<td>clear, cloudy, or bloody</td>
</tr>
<tr>
<td><strong>LDH</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- absolute</td>
<td>&lt; 200 U/l</td>
<td>&gt; 200 U/l</td>
</tr>
<tr>
<td>- fluid:plasma</td>
<td>&lt; 0.6</td>
<td>&gt; 0.6</td>
</tr>
<tr>
<td><strong>Protein</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- absolute</td>
<td>&lt; 30 g/l</td>
<td>&gt; 30 g/l</td>
</tr>
<tr>
<td>- fluid:plasma</td>
<td>&lt; 0.5</td>
<td>&gt; 0.5</td>
</tr>
<tr>
<td><strong>pH</strong></td>
<td>&gt; 7.2</td>
<td>&lt; 7.2</td>
</tr>
<tr>
<td><strong>Glucose</strong></td>
<td>&gt; 2.2 mmol/l</td>
<td>&lt; 2.2 mmol/l</td>
</tr>
<tr>
<td><strong>WCC (PMN's)</strong></td>
<td>&lt; 1,000 / ml</td>
<td>&gt; 1,000 / ml</td>
</tr>
</tbody>
</table>

\(^1\) LIGW states < or > 1000 IU ??

### Other Tests

- **a. microbiology**
  - M,C&S
  - stain & culture for AFB’s

- **b. cytology**
  - malignancy

- **c. "blood picture"**
  1. **eosinophilia**
     → ? drug induced
  2. **RBC's > 100,000**
     - traumatic tap, trauma
     - malignancy
     - pulmonary emboli, infarction

- **d. amylase > 50-60 IU**
  → - oesophageal rupture
  - pancreatitis
  - rarely in malignancy

- **e. chylous**
  - high TG / low cholesterol
  ± high amylase

- **f. ANA**
  + low C' & low glucose
  → collagen vascular disorder

**NB:** despite full evaluation, no cause will be found in ~ 25% of patients
CHYLOTHORAX

- the thoracic duct starts as an extension of the cysterna chyli in the upper abdomen
- enters through the aortic hiatus and ascends extrapleurally between the aorta and azygous vein
- at the level of T₅, crosses to the left border of the oesophagus, ascending behind the aortic arch and subclavian artery
- it enters the venous system at the junction of the internal jugular and subclavian veins
- between 40-60% have anomalies of the course

- **Aetiology**
  a. congenital
  b. traumatic
  c. surgical - any thoracic procedure
     - rarely dissection of the neck
  d. infiltration or extrinsic compression *especially lymphoma
  e. thrombosis of the left subclavian vein

- **Biochemical Characteristics**
  a. sterile, "milky" fluid - alkaline, pH ~ 7.4-7.8
     - SG ~ 1012-1025
  b. amylase (+)ve - pancreatic enzymes present
  c. contents:
     - total fat ~ 4-60 g/l
     - total protein ~ 20-60 g/l
     - albumin ~ 12-41 g/l
     - globulin ~ 11-30 g/l
     - glucose ~ 3-11 mmol/l
     - lymphocytes ~ 400-6,000/µl
     - erythrocytes ~ 50-600/µl
     - U&E's ~ plasma

- **Treatment**
  a. chest drain
  b. low fat diet
  c. TPN
  d. indications for surgical correction,
     i. drainage ≥ 1500 ml/d
     ii. failed conservative Rx after 14 days
     iii. metabolic complications
PHRENIC NERVE PALSY

■ Unilateral

a. idiopathic
b. congenital
c. mediastinal mass
   - tumour, lymph nodes
   - thyroid, thymus
   - aortic dissection
d. trauma
   - cervical
   - surgical, post-CABG
e. local anaesthetics
   - interpleural, interscalene
   - stellate ganglion
f. features
   i. asymptomatic
   ii. small fall in VC
   iii. elevated hemidiaphragm on CXR
   iv. no movement on double-exposure CXR

■ Bilateral

a. cervical cord damage
b. motor neurone disease
c. polyneuropathies
d. poliomyelitis
e. mediastinal tumour
f. congenital
g. "cryoanaesthesia" of phrenic nerves during open-heart surgery
h. features
   i. paradoxical respiration
   ii. respiratory failure
   iii. large decrease in VC
   iv. failure to wean from IPPV after CABG
Pulmonary Function Testing

- reasons for performing PFT's include,
  1. identification of the type of lung disease - obstructive vs. restrictive
  2. quantification of the extent of lung disease
  3. determination of the response to therapy
  4. monitoring the rate of progression

- the value of PFT's is most clearly demonstrated in those undergoing pulmonary resection
- for other surgery, there is little evidence of benefit as a routine screening technique, in the absence of clinical symptoms
- patients who may be considered for PFT's include,
  1. patients with chronic pulmonary disease / symptoms
  2. heavy smokers with a history of chronic productive cough
  3. patients with chest wall or spinal deformities
  4. morbidly obese patients
  5. elderly > 70 years
  6. patients for thoracic surgery
  7. patients for major upper abdominal surgery

NB: the objective of testing is to predict the likelihood of postoperative complications, no single test is the best predictor of complications

- Hall et al. (Chest 1991) showed,
  1. single best predictive factor was the ASA classification
  2. followed by site of incision - upper vs. lower abdominal
  3. age, smoking & obesity also ranked highly

NB: ASA grading may have in part been based on PFT's, but clinical assessment remains the best predictor

- a single spirometric study can provide FVC, FEV1/FVC, FEF25-75%, PEFR and VC
- "normal" limits are obtained from a sample population (Morris 1971) and the lower limit taken as 1.64 x SEE (SD of the regression line) below the same weight & height on the regression line
- this range should by definition include ~ 95% of the population
- the widely used practice of taking 80% of the predicted value should be avoided
- abnormalities on spirometry correlate with the incidence of postoperative complications
- however, the incidence and severity of postoperative complications do not correlate with the severity of the preoperative lung dysfunction
Clinical Spirometry

1. **vital capacity**  
   - effort independent, performed without concern for rapidity of exhalation  
   - decreases may be associated with restrictive lung disease, following excision, or  
     from extrapulmonary factors, ie. chest wall disease

2. **forced vital capacity**  
   - during forced exhalation FVC < VC with significant dynamic airways closure  
   - principally disorders with increased airway resistance, or destruction of supporting  
     architecture

3. **forced expiratory volume, 1 second**  
   - usually expressed as a percentage of FVC, where FEV₁/FVC > 80%  
   - largest observed FEV₁ and FVC from 3 readings are used, even if different curves  
   - reduced mainly by increased airways resistance, usually normal in restrictive defects

4. **forced expiratory flow, 200-1200**  
   - peak flow can be measured by drawing a tangent to the steepest part of the curve  
   - more commonly the average flow over 1000 ml, after the initial 200 ml of  
     exhalation is used  
   - this is slightly lower than the true peak flow, normal values > 500 l/min  
   - values < 200 l/min are associated with impaired cough & postoperative sputum  
     retention, atelectasis and infection  
   - markedly impaired by obstruction of larger airways & responsive to bronchodilator  
     therapy  
   - results are extremely effort dependent

5. **forced midexpiratory flow, 25-75%**  
   - less effort dependent than PEFR, as avoids the initial highly effort dependent part of  
     the expiratory curve  
   - however, still affected by patient effort and submaximal inspiration  
   - values in healthy young men ~ 4.5-5.0 l/s (300 l/min)  
   - abnormal values < 2 l/sec (120 l/min)  
   - initially thought to be more sensitive in detecting small airways disease cf. FEV₁,  
     but this has not been supported

Maximum Breathing Capacity  

- patient is instructed to breath as hard & fast as possible for 12 seconds  
- extrapolated to 1 minute, expressed as l/min, normal ~ 150-175 l/min  
- predominantly affected by increased resistance & correlates well with FEV₁ (MBC ~ FEV₁ x 35)  
- 80% of MBC can be maintained for ~ 15 minutes  
- affected by patient cooperation & effort
Respiratory Muscle Strength

1. $P_{\text{Imax}} \sim -125 \text{ cmH}_2\text{O}$
   < -25 cmH$_2$O reflects inability to take an adequate inspiration
2. $P_{\text{Emax}} \sim 200 \text{ cmH}_2\text{O}$
   < 40 cmH$_2$O reflects inability to cough

Airway Resistance

- using a body plethysmograph, panting against a closed then open shutter,
  1. shutter closed $\rightarrow$ Boyle's law & lung volume
  2. shutter open $\rightarrow$ $R_{\text{AW}}$ calculated from $\delta V$ and flow
      $\rightarrow$ $G_{\text{AW}} = 1/R_{\text{AW}}$
  3. specific airway resistance and conductance are calculated for the given lung volume

NB: a mouthpiece is used to remove the effects of the upper airway, panting is used to keep the larynx dilated

- in ventilated patients, may use peak to plateau $\delta P / \text{instantaneous flow at } P_{\text{pAW}}$
- bi-exponential decay from $P_{\text{pAW}}$ to plateau,
  1. first phase due to airways resistance
  2. second phase due to "stress relaxation"

Alveolar-Arterial Oxygen Gradient

- normal gradient on room air $\sim 8 \text{ mmHg}$
  $\rightarrow$ increasing with age $\sim 25 \text{ mmHg at } 70 \text{ yrs}$
- increased commonly in smokers & mild early chronic bronchitis

Frequency Dependent Compliance

Def'n: abnormal where $C_{\text{Dyn}} < 80\%$ of $C_{\text{Stat}}$

- decreases early with small airways obstruction
- both measurements require insertion of an oesophageal balloon, with flow measured by a pneumotachograph,
  1. $C_{\text{Stat}}$ - inspiratory slope of a static pressure volume curve at tidal volume
  2. $C_{\text{Dyn}} = \delta V/\delta P_{\text{IP}}$
**Flow Volume Loops**

- differentiation of intrathoracic / extrathoracic obstruction
- the entire inspiratory, plus the immediate expiratory portions of the curve are highly *effort dependent*
- ratio of expiratory flow:inspiratory flow at 50% TLC ~ 1.0
- upper airway obstruction inspiratory flow is reduced disproportionately & EF:IF$_{50\%}$ > 1.0
- other patterns described on flow-volume loops,

1. **fixed obstruction**
   - no significant change in airway diameter during inspiration/expiration
   - EF:IF$_{50\%}$ ~ 1.0, with both curves showing a flattened plateau

2. **variable obstruction**
   i. extrathoracic
      - vocal cord paralysis
      - chronic neuromuscular disorders
      - marked pharyngeal muscle weakness
      - obstructive sleep apnoea syndrome
      - accompanied by inspiratory stridor & flow resistance
      - EF:IF$_{50\%}$ > 2.0
   ii. intrathoracic
      - tracheal & bronchial tumours
      - tracheomalacia
      - vascular rings, thoracic aortic aneurysm
      - accompanied by expiratory airway compression & ↑ flow resistance
      - inspiration may be normal, with EF:IF$_{50\%}$ < 1.0

**NB:** differentiation is most accurate in the *absence* of diffuse airways disease

---

**Multiple-Breath Nitrogen Washout**

- normal lung behaves as a single compartment, with a single exponential washout curve for N$_2$
- there is a direct correlation between abnormal N$_2$ washout and frequency dependent compliance
- uneven distribution of *time constants* is believed to be the basis of both
- curve analysis is tedious, requiring computer analysis
**Single-Breath Nitrogen Washout**

- originally described by Fowler in 1949, but adapted to,
  1. full inspiration from RV to TLC with 100% O₂
  2. expired N₂ concentration measured
  3. line of best-fit drawn through the alveolar plateau
  4. increase in [N₂]/l quantified → δN₂ % per litre
     i. normal ~ 2% / l
     ii. smokers ~ 10% / l
     iii. abnormal in ~ 50% of asymptomatic smokers,
        • therefore *sensitive* index of early lung dysfunction
        • *poor specificity* due to large number of asymptomatics who do not progress
to CAL

- the original technique by Fowler involved only 1000 ml O₂ from FRC and due to preferential
  ventilation of the bases resulted in a steeper plateau

**Forced Expiratory Flow Rates**

- difficulty defining abnormal flows at low lung volumes
- during expiration early flow resistance is in the *large airways*, where flow is predominantly
turbulent
- comparative curves using He/O₂ show increased flow in the early expiratory phase
- as expiration continues, the site of resistance moves proximally toward the alveoli, where flow is
  predominanlty laminar, and unaffected by altered gas density (He)
- therefore, at some point, the *volume of isoflow*, the two curves rejoin
- with small airways disease, flow becomes less density dependent and the difference between
  maximum flow rates decreases, and the V_isoV increases
- normal values for V_isoV ~ 10-15% of VC
- values > 25% are abnormal